Big Data, Public Services and Public Acceptance. Who Benefits?
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Exactly what the Big Data agenda will deliver is open to debate. For some, its potential to pull together private and public datasets will provide behavioural insights that address an array of important policy issues. Others, more sceptical contend its impetus arises from the desire to open up public services and its information to commercial enterprise.

One area that remains contentious is the extent to which Big Data is acceptable to the wider public. Privacy campaigners argue that the dominant public assumption is that the data they share as they encounter public services is for use within the context of their own experiences. As set out in the Herbert Report, and a Scottish Government Report on the Public Acceptability of Data-Sharing, there is little expectation that their data will be used for other purposes and little appetite for its wider use.

However, is it possible that there is now an ambiguity regarding the notion of public anxiety? This emanates from two perspectives. The first is that the conspicuous use of social media platforms to share personal information is evidence of a more relaxed approach to privacy. The second derives from the impact of the 'marketisation' reforms that are changing the face of how public services are delivered.

For example, in the NHS specifically, the impact of marketisation has been significant regarding the way in which the collection of data and the purpose of information is perceived. By creating a new 'mindset' around its role in defining value, access rights and ownership, 'data' in this context became something more than a set of descriptors of health 'events'. It has come to act more as a catalyst to drive cultural change and service transformation. This has been a trend that indelibly shaped subsequent technology developments and gathered momentum amidst the creation of large redesign programmes that introduced a modernisation agenda closely linked to a market narrative replete with the language of a corporate enterprise.

This was reflected in key elements of the National Programme for IT's (NPfIT) functional specifications, most obviously through Choose and Book with its focus on *choice* and the erstwhile Data Spine which could act as a trading hub between Commissioners and Providers. Data now became associated with capturing health interventions as 'currencies' against which fiscal goals could be achieved, performance against targets monitored, and income optimised – not least as the panacea to the NHS's perceived problems surrounding 'inefficiency' and productivity. A repeated emphasis on change management and transformation, whilst stressing the centrality of information to realise strategic aims linked to consumer choices and 'producer' behaviours, reinforced the emerging relationship of the *idea* of data with market values.

Factual – Measured - Critical

In this environment, the collection and exchange of information to support invoicing and 'payment by results' became a priority and crucially, a means to stimulate the market through consumer pressures and competition. Its potency as a cultural signifier of intellectual as well as organisational competency was not insignificant. Michael Sandel, in his recent book, *What Money Can't Buy*, aptly describes how this rise of market prestige at the expense of other values ultimately acquires the power of a normative process that shapes how people see themselves and their interpretation of professional identities. The most immediate consequence in the NHS was that data - in all its forms - acquired a heightened importance for professionals at all levels, including clinicians, whose treatments and interventions constituted the very information on which an invoice would be paid. So, what previously existed as a specialist set of skills, became a generic requirement that permeated a range of organisational roles, functions and identities. Indeed, the drive to reformulate clinicians as managers meant them adopting a closer relationship to strategic information goals not only as a precursor to them acquitting their corporate roles but also as precursor to their Trusts acquiring greater autonomy and freedoms within the internal health market. The complexities and conflicting pressures of this trend are not insignificant, with recent examples of major catastrophic hospital failures highlighting the dangers of seeing data through a predominant financial prism.

As the reinvention of information proceeded at pace, the advent of greater processing power allied to new software capabilities, meant that information as a work 'ethic' as well as an outcome became integral to an employee's personal working environment and space. Increasingly work tasks became data-centric focussing on production and validation so that almost everybody was deemed to be an information asset in pursuit of organisational efficiency and the leaner systems mentality required to 'win' contracts from commissioners. This had obvious implications for how individual performance was evaluated and how each saw his/her relationship to data. From a position where information had been about 'practice' it now became about 'practice plus finance'.

In this context, data is as much an idea as it is a calculus. It operates by both articulating the notion of 'data as an instrument' as well as further down the line the notion of 'data as evidence'. It does not simply exist as 'facts and figures' but acts as a set of ideological signifiers that carries a narrative through which we invest in explanations of practice, problematics and solutions.

As the NHS culture became increasingly commodified, the fact that successive governments further introduced the potential for greater *direct* private sector involvement also raised further questions about attitudes to data ownership and access. As more and more services were outsourced, so the boundaries between public and private have become increasingly blurred. A debate began in earnest about the sensitivity of data and the dangers of proliferation highlighted by the risks associated with data protection, privacy and security. Nowhere was this more scrutinised than in the NHS where powerful stakeholders from Clinical Bodies, Patients Groups and Privacy Campaigners sought to reinforce privacy rights on what could be done with data and how it could be used.

This proved a key issue for those who wished to see unhindered transactional flows of personal data to support market choices and it is no surprise that the balance between data access, privacy, ownership and consent has again been brought into sharp focus by the [Health and Social Care Act 2012](#), which put clinicians at the centre of commissioning. Concern that key safeguards have been reduced remain a strong reminder of what is at stake.

So it is in this context that the commodification of public services over the last decade and its concomitant association of data with notions of 'value' strongly aligned with market identities, might have laid the foundation for a cultural shift that encourage a wider public accommodation of Big Data and its corollaries - data linkage, open access and third party usage. In essence, it begs the question of whether working in an environment where performance and achievement is tied up with the logic of market dynamics eventually encourages an assimilation of those values in other contexts.

The rasion d'être behind Big Data operates as much at the level of economic discourse as it does a framework for achieving significant benefits in socially progressive outputs. Clearly there will be commercial companies who, to a greater or lesser extent, will advantageously exploit public data for its financial potential. The relationship of Big Data to UKplc is well documented. A concern must also be that the Big Data agenda will bring the spectre of 'Big Brother' much closer as connections are made across data boundaries and pathways. But what of Academic Research? Researchers seeking to identify genuine insights will need to demonstrate that their work can deliver a radical set of political and social outcomes as an alternative to the commercial penetration envisaged by the private sector. Without this why would the public wish to disclose or share its data?

However, the danger remains that the language, operational context and policy thrust that surrounds Big Data will frame funding models and research relevance in a way that is incongruous with traditional social science paradigms and priorities. Arguably, its major impact maybe to redesign the social science research landscape away from a traditional focus on structural determinants and more towards analytical models that focus on policy imperatives related to efficiency, and risk behaviours across different domains.

After a decade of an ideological diet of market logic, competition and private sector prestige, the public mood may indeed have become more accommodating to the idea of Big Data, but in many ways the jury is resolutely out. In particular, how health records fit into the Big Data project will be a highly contested domain. What happens next regarding the data held within them will be crucial as to how the public comes to define what Big Data means in practice. It is then, that the future of Big Data and NHS, alike, will meet its biggest test.

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