Democratic deficit and communication hyper-inflation in health care systems

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Abstract

There is a widespread perception of poor performance and reduced trust in relation to health case systems. The roots of this problem are interpreted in terms of the democratic deficit and communication hyper-inflation. The democratic deficit is characterized as a persistent but chronically unsatisfied demand for complete public authority over all significant societal institutions – including the health care system. However, such professional institution systems necessarily perform their functions using specialized internal languages, which are not transparent to external scrutiny. Furthermore, professional institution systems tend to eliminate all subjective and imprecise criteria, such as individual moral values. This situation encourages communication inflation, which describes the large and unpredictable divergence between the real and nominal informational content of communications. Hyper-inflation is generated by the development of morality-free information management sub-systems (specifically public relations and advertising) to the extent that 'official' communications convey almost zero reliable information. Reduction of the democratic deficit and control of communication inflation depends upon successful penetration of the health care system by representative public values, including individual morality.

Introduction

There is an international sense of crisis in relation to health care systems - countries differ, but all apparently share a perception of deep problems in providing comprehensive, effective and efficient health care. The crisis can be encapsulated as having two main aspects: the perception of poor *performance* in the systems and a reduced level of *trust* in the way that the services are provided, managed and measured. These can be seen as consequences of two phenomena which characterize 'expert' services in modern industrial society: inflation of communications and the democratic deficit.

Professional Institution Systems

Human society can be understood as a system of communications that - in total - perform the function of information processing (Pokol, 1992, Luhmann, 1995).

The objective of this information processing is to increase the *predictive stability* of the society - the ability of the society to adapt to environmental change, such that it can maintain the course of its intended development. In particular, the intended development of modern societies is primarily to maintain economic growth. This is necessary for many reasons, for example sustained economic growth seems to be essential for the stability of modern societies (Gellner, 1988), a relatively slow rate of growth compared with competitors will render societies vulnerable to economic colonization (Wright, 1999), and also economic success is regarded as the best guarantee of electoral success (as in the 1992 Clinton campaign catch phrase 'it's the economy, stupid!').

As Adam Smith famously described, economic growth depends mainly on productivity gains made possible by division of labour. The consequent specialization of function implies ever increasing amounts of specialized communications in order to coordinate the divided labour. Elaborate and interlocking division of labour requires greatly increased logistical organization and exchange of information in order to coordinate the many diverse activities. To coordinate a *national* health care system requires exceptionally high levels of information exchange.

This informational complexity leads to the formation of professional institution systems whose role is to coordinate specific aspects of human activity (Pokol, 1992, Luhmann 1995). In modern industrial societies there are many such systems - some of these are represented by the major divisions of government such as the legal system, the education system, and systems of economic and monetary management. The health care system represents one of the largest.

Professional technical languages

These professional institution systems are managed and implemented by 'elites' of skilled professional experts (eg. doctors, lawyers, economists), who command large resources including personnel. These groups tend to develop distinctive fundamental values (termed 'evaluation dogmas'; Pokol, 1992), such as due process in law, profitability in economics, or the treatment of illness in the case of medicine. Such evaluation dogmas structure and permeate the specialized communication system.

Systems of specialized communications can therefore be understood as comprising a specific professional 'language' (Pokol, 1992). Their linguistic features include a distinctive vocabulary ('lexicon') and

distinctive rules of reasoning (‘syntax’). Such languages are sometimes termed a ‘technical jargon’. An example of this kind of professional language would be the abbreviated but very exact vocabulary and structure of referral letters that pass between a consultant specialist and a general medical practitioner. Another example would be the internal letters, instructions and memos that circulate within the Department of Health and the Health Authorities. Such languages are hardly understandable by outsiders, and in consequence the information processed using a such language is accessible only to those who have mastered the language and are a part of the related professional institution system.

The function of professional languages is to handle complex communications. Complex information is filtered, summarized and rendered into a standard vocabulary, and dealt-with in a routinized form of processing that is adapted to that activity. Technical communications within the professional sub-system are therefore made clear, precise and unambiguous - especially as compared with non-technical communications that exist external to the system. And these qualities mean that specialist professional communications provide the stability necessary to enable prediction and planning.

The information-processing role of institutions that act as professional systems, and the fact that they deal with highly complex activities, means that these organizations typically require specialized institutional processes and forms of internal organization. For example, medicine is characteristic in being linked to formal mechanisms for recruitment, training, certification and evaluation, incentives and promotion processes.

On top of this, professions usually emphasize a special type of *morality* which is enforced mainly by internal mechanisms. In medicine such

ethical functions are formally embodied by the General Medical Council, but actually permeate many aspects of education and practice (Downie & Calman, 1987). These ethical aspects of professionalism serve to assure external agents that power and privileges will not be abused.

Inter-penetration of professional institution systems

While professional institution systems are relatively autonomous, and develop around specific societal functions that are amenable to a common set of information processes, there is naturally some degree of inter-penetration (Pokol, 1992).

For example, medicine and law function independently for most of the time, but there are important ways in which the legal system penetrates the health care system. Medicine will always be practiced with some kind of implicit deference to the legal framework, and this deference may be more or less constraining. Where legal sanctions are severe and frequent, medical systems and practices may become explicitly designed around their compliance to the legal system. For instance, a doctor may practice 'defensive medicine' - which could be defined as treating the patient with the primary goal of avoiding the possibility of litigation, and only secondarily pursuing the distinctive goals of the health care system.

The spontaneous pursuit of self-interest by professional institution systems ensures that competitive attempts at inter-penetration are a recurring feature (Pokol, 1992). Such inter-penetration may improve, damage or leave unaffected the predictive accuracy of the specialized communication processes. On the one hand, the existence of 'external scrutiny' may act to diminish corruption or inefficiency in a system, on

the other hand the imposition of inappropriate categories and modes of information-processing may reduce effectiveness.

The British health care system has recently been penetrated not just by law, but by politics, economics and accountancy. The effects can be observed by changes in the lexicon and syntax, which have taken-on terms derived from other areas of discourse - such as politically-generated managerial argot, economics-generated focus on pricing and efficiency, and accountancy-generated systems of audit and quality assurance.

Communication inflation

Monetary inflation involves a continual rise in prices, which translates as a decline in the real world value of money. Communication inflation involves a similar process, whereby the claims of professional institution systems are continually becoming greater than their real world value.

But inflation has a more deeply damaging aspect than this preliminary definition suggests - essentially inflation is a decline in the *informational content* of prices; and the main problem is not continually rising prices, but the *unpredictability* of price rises (Mankiw, 1999). The outcome is that the price no longer communicates information about the value of a commodity.

When monetary inflation is merely a modest and regular annual price rise of a few percent this presents no serious economic problem, because the percentage inflation can simply be included in planning. The economic problem occurs in hyper-inflation - such as occurred in Germany during the nineteen twenties. Price and wage rises were both large and unpredictable (technically, price and wage *variance* was large), such that nobody could plan more than a few hours or days ahead. The nominal

monetary value ceased to have an understandable relationship with the real world value of goods or services. In other words, price was no longer operating as a reliable signal for economic communication.

The same principle applies to other forms of communication. When there is a modest and predictable *exaggeration* by professional institution system communications with the external world, then the communication still serves as an effective source of information because observers in the real world can simply subtract (or discount) a predictable amount. But when communication hyper-inflation sets in, then the nominal communication ceases to convey any real world information.

In the 1990s, the National Health Service in the UK generated an internal language of 'performance indicators' for communication of targets and attainments within the health care system (Ham, 1992). These statistics have strict operational criteria - such that the way that such data are defined, recorded, collected, analyzed and communicated are explicit and closely controlled. So, within the specialized system of the NHS managerial hierarchy this information is relatively precise and unambiguous, and forms the basis for monitoring, prediction and planning - and this information also determines the salary and status of professional managers.

However, public communications of the NHS managerial hierarchy have probably reached the level of hyper-inflation. Announcements from the Department of Health are usually honest, according to formal, internal professional criteria. But the 'real world' value of such announcements is unpredictable. The informational content may be hugely exaggerated - such as the regular reports of the continual and substantial improvement in NHS services. On the other hand, the informational content may be highly accurate using external real world criteria - such as recent

announcements that the MMR (measles, mumps, rubella) combined vaccine is safe (Fitzpatrick, 2002).

The external observer cannot simply subtract a standard degree of exaggeration from official Health announcements, because information *may* be accurate, or there may be there may anything from moderate to massive degrees of exaggeration - especially when some officials try to compensate for expected discounting. For example, the misleadingly exaggerated and incomplete official information about the hazards of AIDS infection in the mid-1980s seems to have been an attempt to generate behavior change in the face of widespread public cynicism about the value of official information (Fitzpatrick, 2000)

A tendency towards hyper-inflation is a defining characteristic of the externally-oriented communications of professional institution systems in which trust has so eroded that communications have ceased to function as information transfers.

Elimination of personal morality

While specialized professional languages usually work well for internal purposes, they require to be 'translated' for the purposes of external communication. 'Inflation' occurs because the nominal and real content of communications tend to become uncorrelated. This tendency can be understood in terms of the decreased role of individual morality in professional institution systems (Pokol, 1992).

The functional optimization of professional institution systems entails eliminating imprecise and subjective considerations, and selecting the minimum number of technically-suitable criteria for the needs of information processing. Such eliminated criteria include individual moral

values (MacIntyre, 1999), which are notoriously imprecise and subjective. Within professional institution systems, moral values can only be made stable and predictable when operationalized in terms of surrogate data and processes that are amenable to quantification and standardization. The successful elimination of individual morality provides efficiency benefits, but may lead to highly inflated communications.

Individual moral values provide a check on the relationship between the internal and 'real-world' value of communications (Havel, 1992). When specialist professionals morally evaluate their specialized activities, this provides a feedback loop which tends to prevent excessive divergence of internal and real-world languages. However, this evaluative role of personal morality inevitably leads to subjective and unpredictable decisions, reducing the stability of information-processing, and tending to reduce the purely technical performance of the professional system. So, despite the efficiency-damaging effect of individual morality, there seems to be an appropriate level of penetration of any specialized technical system by moral values. Without the check of individual morality, the phenomenon of 'over-professionalisation' of a sub-system will tend to develop, and the technical world and the external world will end-up speaking what are literally different languages.

For instance, from 1992 mental health service targets were monitored simply by the suicide rate statistic - which was only one outcome measure of mental health among many, many possible others (Charlton, 1994). Although the measure has advantages of simplicity and precision, its real-world relationship to the effectiveness of mental health care services is conjectural, and its value as a integrative surrogate measure of these services unproven. The consequence is that the suicide rate measure has a

very different status within the health care system and outside that system. So long as suicide rate performs well as an internally-used surrogate measure of mental health, then the NHS managerial hierarchy is satisfied. But when such information is communicated to the external world, technical definitions need to be translated into common language equivalents - so that decline in suicide rates might be 'translated' as a real world improvement in the effectiveness of mental health services.

No deliberate dishonesty is involved here. Improvement as defined by specialist managerial information systems is entirely compatible with decline according to the external world criteria. If individual moral evaluation has been eliminated from a professional system, then disparities between the nominal values of technical information and their real world values are allowed whenever it is expedient, and to whatever extent is most expedient. Communication inflation may proceed unchecked leading to hyper-inflation.

Democratic Deficit

The democratic deficit is the gap between public demands to monitor and control the activities of professional sub-systems and the achieved level of monitoring and control.

The deficit arises because one of the fundamental evaluation dogmas of modern western societies is that there ought to be democratic authority over all significant aspects of public life (Bealy *et al.*, 1999). In the NHS, the deficit is seen as the gap between the 'ideal' of a democratically-controlled health care system - and the actuality of a largely autonomous professional institution system, able to pursue its own agenda regardless of democratic wishes.

The democratic deficit is exacerbated by communication hyper-inflation, which obscures the gap between expectations and reality by exaggerated claims. Official communications routinely claim that the health care system closely conforms to the democratic ideal (or will shortly do so), but the public does not trust these official communications.

The democratic deficit may also be obscured by the existence of regulatory professional sub-systems charged with the application of democratic control to primary sub-systems. In order to perform a democratically-regulatory role, such institutions would need to demonstrate both their democratic credentials and their effectiveness at imposing control. But it is very unusual for professional regulatory institutions to accomplish both of these objectives.

Within the health care system there are vast numbers of official regulatory institutions that are empowered to force their will on health care providers (36 are listed by Willis (2001), but this list is incomplete). However, such institutions typically lack democratic credibility. As a recent example, since 1999 the National Institute for Clinical Excellence (NICE) has been charged with overseeing the rational use of pharmaceuticals and other technologies in the NHS. However, NICE is constituted as an branch of the health service bureaucracy and is staffed by political appointees and technical specialists (Miles et al, 2000). Rather than an instrument of democratic will, NICE is itself a demonstration of the democratic deficit, and its public communications display all the hallmarks of communication inflation. When the anti-influenza drug Relenza was recommended as inappropriate for NHS use, NICE quoted a measure of its effectiveness that was technically accurate (based on the 'intention to treat' statistic), but which was translated to

generate an underestimate of the drug's clinical usefulness which (expediently) supported NICE's decision (Charlton, 2001).

In practice, although purportedly democratic, existing NHS regulatory institutions merely function as additional professional institute systems. Not only do they fail to reduce the democratic deficit and control communication inflation, but they actually multiply the scale of the problem.

Alternative institutions

The democratic deficit is characterized by a persistent but unsatisfied demand for public authority over professional institution systems. The failure of professional sub-systems is indicated by communication inflation which increases the democratic deficit until reformist tendencies are triggered.

When the public are unsatisfied by official regulatory responses, this demand will usually generate alternative 'unofficial' professional communication systems that more closely represent grass-roots public opinion. For example, in the UK health care system this kind of role is performed by charitable associations representing sufferers from various diseases, by the Consumers Association, and by lobby groups for special interest groups (eg. womens' health, the elderly, the homeless etc.). Such institutions generate public communications that are often perceived to be more honest than official sources. Such 'grass roots' credibility may combine with organizational influence on pressure on the political system (by mobilizing electoral support, lobbying, influencing parties through donations to political funds etc.) and support efforts at penetration of the health care system via the administrative and legal sub-systems in the

form of new and more binding regulations. Similarly, the media may also represent themselves as champions of popular opinion; and investigative journalism may be directed at uncovering and remedying abuses in the health care system, and exposing discrepancies between official claims and real world performance.

However, when professional institution systems are failing and such reforms are ineffective, then people may try to insulate themselves from system failure by seeking alternative providers. Such demand may generate institutions that plausibly solve problems of perceived inadequate effectiveness or non-moral behavior. Inadequate state health care systems create a demand for 'private' providers who - since they must compete for clients - may more easily be penetrated by common moral values. Such market-dominated institutions may demonstrate near-zero levels of communication inflation, at least towards their target public (Pokol, 1992).

Inevitability of the Democratic Deficit

Although communication inflation may be kept under control, and the democratic deficit minimized, there is a sense in which these phenomena are inevitable in modern societies.

Highly specialized professional institution systems are difficult to control externally - whether such control be democratic, or of any other kind. This difficulty arises because of the necessarily highly specialized language of their internal communications. Those who lack an understanding of the specialized language are unable to monitor or control such institutions without significantly damaging their functions.

And such a level of understanding may be all but impossible to an outsider.

Highly professionalized institution systems also develop their own morality-free bureaucracies that are very prone to produce highly inflated communication for the outside world. A clear example is provided by the ever-increasing role and scope of public relations and advertising within the NHS. The health care sub-system in charge of external communications, functions explicitly to generate expediently biased information. Such communications may be able to thwart external attempts to oversee, monitor and control. Of course, hyper-inflation is eventually recognized, and generates public demands for greater democratic control; but increasing public dissatisfaction may be assuaged (or confused) by yet further investment in communications management, allowing further inflation.

In sum, the democratic ideal is for authority over professional institution systems. The political reality is one of a social system run by near-autonomous professional institutions. Yet the nature of this situation is obscured by endemic communication hyper-inflation, exacerbated by morality-free information management. Information is abundant, but so unreliable that the magnitude of the problem cannot accurately be evaluated. The outcome is a substantial democratic deficit.

In principle, more democratic and effective regulation of professional institutions could reduce the democratic deficit, and an increased role for individual morality could impose controls on communication inflation. But at present, it seems that the problems of a comprehensive national health care system cannot ultimately be solved. If attempted reforms continue to fall short, ultimately smaller scale and less comprehensive alternative systems will arise.

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