Remembering
Professor Gavin Mooney

Director of HERU
Professor Gavin Mooney (1943—2012)

Gavin as a wee boy

Graduating from the University of Edinburgh

And returning to be Director of HERU (1991—1993)
As we celebrate 40 years of Health Economics at the University of Aberdeen we also remember and celebrate the contribution of one of the Founding Fathers of Health Economics, Professor Gavin Mooney. Gavin, along with his partner Del (Delys) Weston, tragically lost their lives in December 2012.

Having graduated in Economics from the University of Edinburgh (1969), and worked at the UK Government Economic Service in London, Gavin came to the University of Aberdeen in 1974 to work on a project with Professor Roy Weir and Elizabeth Russell concerned with bringing Medicine and Economics together. This laid the foundations for an application to the Scottish Home and Health Department (now Scottish Government Health and Social Care Directorate) to establish the Health Economics Research Unit (HERU). Gavin was the inaugural Director of HERU, directing the Unit between 1977 and 1986 and again between 1991 and 1993. In 1984 Gavin became the first Professor of Health Economics in Scotland.

Part of Gavin’s attraction to the first formally funded Health Economics project in Scotland was a belief that Health Economics is the caring side of Economics that could be used to achieve social justice. He was also keen to return to his beloved Scotland.

Gavin’s legacy lives on in HERU 40 years after his arrival in Aberdeen. A key component of HERU’s remit is capacity building. Gavin was a fantastic teacher and recognised the importance of teaching economic concepts within the health service. With much vision, Gavin set up the Health Economics Correspondence Course in 1979, a distance learning course aimed at health professionals. This course is still a key vehicle for teaching at HERU.

Gavin inspired researchers to challenge Health Economics, to push the discipline forward, and always to strive for a health care system based on the principles of social justice. He strongly believed that it was the preferences of patients and the community, as opposed to providers, managers and researchers that should be counted. Such principles underlie much of the work HERU has conducted over the years, and for which HERU is internationally recognised.

We were privileged to have had one of the Founding Fathers of Health Economics contribute to the setting up and development of Health Economics at the University of Aberdeen. Gavin went on to have posts at the University of Copenhagen (1983), University of Sydney (1994) and Curtin University (2001) as well as an Honorary Professorship at the University of Cape Town and Visiting Professorships at the University of Southern Denmark, University of New South Wales and Aarhus University, and an Associate Appointment at the University of Tasmania. He inspired many to challenge Health Economics, to push the discipline forward, and always to remember why we are doing it – to improve both the provision of health care for the community and social justice.

In this document we bring together a collection of obituaries, testimonials and academic articles that demonstrate the impact Gavin had on so many lives – academics, policy makers, medics, health organisations, non-health organisations, patients and public advocacy networks, media, friends and colleagues.

I met Gavin in 1991. A young Research Assistant at HERU, I was amazed when Professor Gavin Mooney, our new Director, asked me to comment on a paper of his! Gavin became my PhD supervisor, mentor and friend. As current Director of HERU I hope I can inspire colleagues as Gavin inspired me.

Professor Mandy Ryan
HERU Director
Gavin’s HERU Team in 1992

BACK ROW—Left to Right: David Torgerson, Cam Donaldson, John Cairns, Julie Ratcliffe, Gavin Mooney, Shelley Farrar, Phil Shackley and Andrew Walker.

FRONT ROW—Left to Right: Carmel Oakley, Brian Yule, Doreen Ellis, Elspeth Horne, Andrew Healey and Mandy Ryan
...selection of obituaries for Gavin that appeared in national newspapers and major international journals
OBITUARY

PROFESSOR GAVIN MOONEY 1943–2012

Professor Gavin Mooney and his partner Dr Delys Weston died on the 19 December 2012 in tragic circumstances in the house to which they had “retired” in Tasmania, Australia. Always active in academic and policy circles and not of a retiring nature, Gavin was in reality still fully occupied with various projects at the time of his death, including writing two further books.

Gavin Hunter Mooney was born in Glasgow in 1943 and went to school in North Berwick. He began working life as a trainee insurance actuary but quickly opted to become an undergraduate economics student at the University of Edinburgh. Graduating in 1969, he started work in the UK Government Economic Service, first in the newly created Department of the Environment and then the Department of Health and Social Security. This experience confronted him with the uncomfortable but unavoidable trade-offs that permeate policy making—for example in road safety, consumer protection, workplace legislation or end-of-life care—and kindled a lifelong interest in cost–benefit analysis and the valuation of health and life in cost–benefit analysis calculations. Not enjoying living in London and having been awarded a year’s leave of absence from the civil service, he moved to the University of Aberdeen in 1974, where he found a supportive and stimulating base in the Department of Social Medicine. He began a book on the Valuation of Human Life (published in 1977), established a close rapport with the Head of Department, Professor Roy Weir, and collaborated in the first research project on healthcare economics. Soon, more ambitious plans were hatched, to create a research centre devoted to health economics based within that department. The result was the Health Economics Research Unit, established in 1977 with support from the Scottish Home and Health Department. From modest beginnings in equally modest accommodation (the “hut”), Health Economics Research Unit flourished and has retained a leading role for over three decades in research, teaching and training even as health economics itself has grown prodigiously. Consequently, Gavin never returned either to live in London or to work in the civil service and instead, launched a career that distinctively influenced the development of health economics, not only within the UK but also globally. In recognition of his “founding father” achievements, he was awarded an Honorary Doctorate from the University of Cape Town, South Africa in 2009.

From his early base in the Department of Social/Community Medicine, Gavin very quickly established interests in the application of economic techniques, concepts and theories, many of which anticipated major fields of enquiry. There were early applications of cost-effectiveness analysis, innovative work on marginal analysis in service planning and resource allocation, and explorations of the importance of incentives in healthcare planning, management and delivery. He built avenues of communication with the local Economics department, while simultaneously promoting applied research across many and varied areas of health care, his reach including the promotion of research in often-neglected areas such as nursing and dentistry. Another set of interests, which remained with him for the rest of his life, drew him to concerns that are often not given the importance they deserve in economic theory. He began writing and developing ideas on equity as applied to health care, notions that procedural (process) elements matter as much as outcomes in judging welfare, and that with social aggregation welfare could encompass elements that were larger than the mere (weighted or unweighted) sum of individual utility, a notion that eventually led him to explore the uses of communitarianism as a basis for evaluating welfare. While always attempting to establish the economic arguments for these notions, Gavin’s publications and teaching
in these areas also reflected his political beliefs that society should be governed by fairness, that humans should be treated with dignity and that hierarchies, especially the medical ones, should always be distrusted. The application of such concepts was paramount to Gavin and directed his practice of economics to the very end, as witnessed by his important role in the establishment of citizens' juries in health care and the social justice network during his later years in Australia.

A great proselytiser, Gavin was keen to ensure that basic economic concepts were understood and used within health systems. This motivated much of his publishing, particularly popular and long-lived books such as *Choices for Health Care* (1980) with Roy Weir and Elizabeth Russell or *Economics, Medicine and Health Care* (1986). As a consequence, as well as involvement in numerous local National Health Service decision making bodies, he initiated what was to become, and remains to this day, an extremely popular correspondence course on health economics aimed primarily at healthcare staff. His objective was to get economics applied widely with the healthcare sector, in line with his fervent belief that explicit and routine application of concepts such as opportunity cost could fundamentally improve the delivery of health care. And not only in the UK – his curriculum vitae records with some pride, his teaching in 29 countries.

His vigour, energy and his passion, not only for health economics, took him on a life long journey that embraced many countries and widened his interests beyond traditional microeconomics. Throughout, he remained strongly attached to a fundamental belief that even basic applications of economic theory could enlighten and improve. For many years, he retained strong attachments to Scandinavia, rolling out a distance-learning programme from the University of Tromso and moving to the University of Copenhagen in 1986. Clearly frustrated with mainstream economics and the rigidity of the continental clinical profession, he returned to the Health Economics Research Unit at University of Aberdeen in 1991. This second Directorship of the Unit saw great expansion in posts and ideas, but for Gavin, there was a feeling that he had already successfully achieved what he personally had wanted within the Unit, and in 1996, following a number of visits to Australia, he moved to a Chair within the School of Public Health at the University of Sydney.

Now a senior academic, Gavin found himself drawn again into the management and capacity building roles he had left behind in Aberdeen. Partially in reaction to this, he moved in 2000 to Curtin University, Perth in Western Australia, where much of his time was spent writing and researching rather than teaching. Throughout this period, he had become increasingly concerned over Aboriginal rights and in particular the access to health care of the Aboriginal people. This became a new passionately held cause that drew together many strands of his beliefs and his thoughts, on the practical meaning of social justice, equity of access to health care, the influence of group participation and commitment in welfare programmes, and the lasting impact that teaching can have on individuals and on public policy. The fact that he was quickly and widely embraced by various Aboriginal groups and individuals is an abiding testimony to deep-seated concern for their plight.

Gavin is survived by his sister Helen and his brother Grant, a retired general practitioner in the Scottish Borders. He will be sorely missed by many.

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The health economist Gavin Mooney was a leading advocate of social justice in the provision of health care. Based in Scotland, Scandinavia and, from the mid-1990s onwards, in Australia, he has died at the age of 69, along with his partner Del (Delys) Weston, after they were attacked at their home in Tasmania.

Gavin challenged assumptions about the economics of healthcare by focusing on what communities wanted, as opposed to the preferences of providers, managers and researchers. His political hero, Aneurin Bevan, had given the title In Place of Fear (1952) to his account of the founding of the National Health Service in Britain: Gavin started from the same principles in judging the NHS.

Market failure to achieve goals of social wellbeing had led to government intervention after the second world war, but inequalities in health persisted over the second half of the 20th century. Gavin was one of the first in his field to argue that equity and efficiency are not opposite sides of the performance coin, but intrinsically linked.

His book The Valuation of Human Life (1977) examined the wide variation in the valuation of human life implicit in public policy decisions ranging from "childproof" medicine containers to enclosed cabins on tractors. Recognising that considerations other than health came into play, he then turned to decision-making in the NHS.

In Economics, Medicine and Health Care (1986, third edition 2003) he presented the concept of process utility – using medical treatment to improve an individual's general welfare. Pre-natal screening, for example, provides all sorts of information to prospective parents, allowing them to plan for the future.

Noting that healthcare systems tended to reflect the priorities of providers within which population needs were expected to "fit", Gavin worked with the Danish philosopher Uffe Jensen on community approaches, detailed in Changing Values in Medical and Health Care Decision-Making (1991), and incorporated these ideas into an alternative view of health economics in Challenging Health Economics (2001).

After moving to Australia in the 1990s, Gavin applied these ideas to improving health and social justice for Aboriginal populations, particularly through use of the "citizens' jury", and remained an active campaigner until his death.

Born in Glasgow, Gavin went to North Berwick high school, East Lothian. He graduated in economics from Edinburgh University in 1969.
After working in the Government Economic Service, in 1974 he took up a post in health economics at Aberdeen University, became director of its Health Economics Research Unit on its foundation in 1977, and professor in 1984. The correspondence course that he developed for researchers, managers and clinicians was influential, and he later also oversaw a distance-learning programme through a part-time post at the University of Tromsø, northern Norway.

In 1986 he moved to the University of Copenhagen, then spent a second period at Aberdeen, and in 1996 went to the University of Sydney. His final chair was at Curtin University, in Perth, Western Australia (2000-08). Of his 200 publications, more than 20 were books. The Health of Nations: Towards a New Political Economy came out last year.

I first met Gavin in 1983 when he interviewed me for a position in the research unit at Aberdeen. Although I took up a position at York University, he remained a valued colleague and friend. He is survived by his brother Grant, a retired GP in Scotland.

- Gavin Hunter Mooney, health economist, born 30 October 1943; died 19 December 2012

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By Cam Donaldson

Founding father of health economics

Born: October 30, 1943; Died: December 19, 2012

Professor Gavin Mooney, who has died aged 69, was one of the founding fathers of health economics and a truly global academic, holding university positions from the most northerly to southerly universities and in between, Aberdeen and Australia and playing significant roles. Through these positions, he drew many people into health economics (and stopped them leaving); many now work in professorial positions at leading universities, including LSE and Oxford.

As well as being an outstanding researcher, Professor Mooney was one of the best health economics educators and mentors. In 2001, the Health Foundation decided to hold a UK-wide competition for £3m of funding for a new chair in health economics. Universities had to apply with named candidates. Out of the five finalists, three had been Aberdeen University PhD students of Prof Mooney.

He was born in Glasgow and after attending North Berwick High in East Lothian, studied economics at the University of Edinburgh, graduating with an MA (honours) in 1969. The degree came after he had tried out life as a trainee actuary at the Standard Life Assurance Company for four years.

From university, he headed into the Government Economic Service, located in London, dividing the four years he spent there between Environment and what was then Health and Social Security. This experience convinced him of the need for economic principles to be applied in socially-important areas where the benefits, such as lives saved and gains in health, are difficult to measure. This took him to the University of Aberdeen in 1974 to work on a prototype health services economics project under the guidance of visionary Professor of Social Medicine, Roy Weir; the word "social" in the title of Weir's chair being one of the attractions.

Prof Mooney wrote more than 20 books (and more than 200 publications in total). One of them, written with Weir and Elizabeth Russell, Choices for Health Care, is still a classic.

The Aberdeen project led to the creation of one of the world's first research centres in the subject, the Health Economics Research Unit (HERU), funded by the Chief Scientist Office of the Scottish Executive. Prof Mooney was inaugural director, becoming Scotland's first Professor of Health Economics in 1984.

A major teaching innovation during this period was the now-famous health economics correspondence course, through which thousands of health services managers and clinicians have been taught how to implement health economics in publicly-funded health services.
During this time, Prof Mooney also found time to write Economics, Medicine and Health Care, one of the best-selling health economics books of all time. Reflecting the influence of his parents on his social values, the book was dedicated "to faither".

By 1986, changes in Prof Mooney's personal life led him to take up a post at the University of Copenhagen, from where his influence spread throughout Scandinavia. He even took up a part-time position at the University of Tromso, developing yet another influential correspondence course, this time aimed at bringing economists into health economics. Further international recognition followed, with honorary positions at Aarhus University (Denmark), Victoria University (New Zealand) and the University of New South Wales, Australia.

By the early 1990s, a return to Aberdeen beckoned. Prof Mooney went back to HERU as director (part-time), commuting between there and Denmark. I was lucky enough to be recruited as his deputy director, an experience which has shaped my whole approach to research management and for which I will be eternally grateful.

Prof Mooney's second tenure at Aberdeen was not to last however. He returned from a short sabbatical in Australia in 1993, to announce that he was heading back there for good, taking up the Foundation Chair in Health Economics at Sydney University and then a professorial position at Curtin University in Perth, which he held until his retirement in 2008. Perth was where he met his wife Del Weston, herself a distinguished academic in the area of climate justice. She died with him in Tasmania.

Professor Mooney made major contributions to health economics – in methods of priority setting, economic evaluation and valuation of life and health. But his time in Australia would be notable for his work on health equity, especially on Aboriginal health, for which cause he became a strong advocate.

One of his proudest moments was his invitation to speak at the Garma Festival of Traditional Culture held in Australia's Northern Territory in 2008. Health economics, and health equity in particular, were great outlets for his feisty and direct nature.

He had no children of his own. He is survived by his sister Helen and his brother, Grant, a retired general practitioner.

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Eulogy for Professor Gavin Mooney (1943-2012)

Throughout his working life, Gavin Mooney believed passionately that health economics was a caring discipline that could be used to achieve social justice. Gavin was a proud communitarian and he argued in every way for a health and welfare system that put people and communities first. Countless students, colleagues, policy makers and politicians can recall Gavin’s most popular refrain ‘How can you run a health system unless you first know what the community want?’ ‘Ask the community’ he’d say. It was more than rhetoric – Gavin backed his good intentions with action, running numerous citizen juries that asked people what they wanted from their health system. Rarely was the answer ‘more of the same’. What did feature consistently in responses was a concern for fairness in our health system and a better balance between prevention and cure.

Community is at the heart of public health and public health was in the heart of Gavin. For many of us our first encounter with Gavin was at the 1987 annual PHAA conference in Sydney. The conference theme was ‘Just Health’. In his plenary talk Gavin declared his genuine affinity for Aussies and then he got straight to the point (as was his style!) – what do we mean by equity in health and what are we going to do to eliminate inequities? And when? He spoke of vertical equity – the unequal treatment of unequals – perhaps better expressed as positive discrimination for those in less fortunate socio-economic circumstances. It was a simple but important concept that Gavin would apply in his work across many countries, including Australia and South Africa.

In 1994 Gavin was appointed the Foundation Professor of Health Economics at the University of Sydney and Westmead Hospital. Seeing the need to build capacity in health economics and to integrate economics into ways of thinking about our health system he had supported the establishment of the Centre for Health Economics Research and Evaluation (CHERE) some years earlier and later the Social and Public Health Economics Research and Evaluation Group. Early career health economists, public health officer trainees and many others benefited from Gavin’s enduring commitment to mentoring individuals to reach their full potential. It is legacy that will benefit public health for many years to come.

During his time at Curtin University (2001 – 2008) Gavin established the WA social justice network. An outspoken critic of institutions, governments and some professional bodies he ruffled feathers and mobilized action for social justice. He could be as feisty as hell but then his Scottish humour and gentleness would emerge, and left you feeling like you had the best friend in the world. No matter what, Gavin had enormous compassion for people and he wasn’t afraid to show it.
Of all his numerous academic achievements – a prolific output of more than 200 publications, 23 books, and being one of the world’s leading health economics educators across generations – there is one achievement that stands out amongst all others. During his time at Curtin University he trained five Aboriginal health economists. It is a remarkable achievement and a true reflection of his commitment to Aboriginal health.

From his earliest days as a professor at the University of Aberdeen (commencing in 1977), then University of Copenhagen (1983), to Sydney (1994) and Curtin University (2001) and through his honorary professorship at the University of Capetown and Visiting Professorships at Southern Denmark, UNSW, Aarhus and Associate appointment at the University of Tasmania, Gavin brought the highest levels of integrity, intellectual rigour, advocacy and inspiration to his role as an academic. Indeed he inspired generations of public health students to question, to think and act about public health problems.

Not one for accolades, Gavin was genuinely moved when the University of Capetown awarded him an Honorary Doctorate as ‘one of the founding fathers of health economics’. It was fitting that some 30 years following the publication of his seminal book ‘Economics, Medicine and Health Care’, which he dedicated ‘to father’ (father) he should be so honoured as father of health economics.

No matter what the language, the culture or country, Gavin Mooney had what Steve Leeder described as a ‘challenging, clarifying and provocative style’. We need more of that in public health. I shall miss him very much.

Glenn Salkeld was a friend and close colleague of Gavin’s for some 25 years.

This article appeared in the February 2013 issue of InTouch—the newsletter of the Public Health Association of Australia Inc and is reproduced here with their permission.
A founding father of health economics

THE world was diminished just before Christmas by the tragic death of Gavin Mooney and his wife Delys Weston, murdered in their home in Tasmania.

Mooney was a standout member of a brilliant generation of economists who carved out a new field of academic inquiry - health economics.

Health economics brings the economist's way of thinking to how health is "produced" in populations and how it can be produced better and distributed more fairly. It involves the study of healthcare systems, payment mechanisms for clinicians, and factors outside the health system that affect health as well (such as employment, taxation and education).

If you have ever heard that hospital A or country Y gets better recovery rates from coronary bypass surgery at less cost than hospital B or country Z, then you are learning from health economists. If you read that building more footpaths increases quality of life and reduces healthcare costs then that is health economic research also.

Mooney was born in Glasgow during World War II. His first job was as an actuary for a large insurance company. Personal experience along with the grim reality of the statistics, that the poor and the wealthy die at different rates, fuelled his passion for social justice. An economics degree from the University of Edinburgh, and a stint with Britain's Government Economic Service (in environment, and then health and social security) followed, before Mooney joined the University of Aberdeen, eventually to develop its health economics research unit, as its foundational director. University postings around the world came next. While Mooney and many of his colleagues worked on the methods and theory of health economics, he felt pressed to put the ideas into service. In 1993 he moved to Australia.

Having been influential in establishing the Centre for Health Economics Research and Evaluation in Sydney two years earlier, he joined the centre and the University of Sydney as its first professor of health economics. He later established the Social and Public Health Economics Research Group to enable him to concentrate on his main intellectual passions: the economics of indigenous health, social justice and supporting the role of communities in decision-making about their health systems. Thousands of economists, doctors, statisticians and health service managers around the world have learnt the meaning of terms like "efficiency" and "health equity" from Mooney. So engaging a teacher was he that they can only think of these concepts with his Glaswegian brogue in their heads. If English is the universal language of flight controllers, then Mooney's Scottish accent is the universal voice of health economics. For this, he was widely loved and deeply admired. His passion for his field, and his dedication to serving others through it, had no bounds. It was infectious.

And he was fearless. In a society where doctors expected to be revered and seen to be "beyond self-interest", Mooney would conduct research asking why the number and types of procedures that
doctors implement vary according to factors unrelated to patient need or treatment effectiveness. Why, for example, do rates of surgery vary according to whether the surgeon is paid by salary or fee-for-service?

He was "disgusted" by the Australian Medical Association's plans to offer financial incentives to induce doctors in developing countries to practise in Australia, leaving the homeland infant mortality rates to soar for lack of personnel. He was "astonished" at Kevin Rudd's lack of understanding of clinical power plays. On the day he died, his letter in The Age questioned why federal Labor claimed to be proud of Australia's contribution to international development given that data from the Organisation for Economic Co-operation and Development shows us to be in the bottom third of countries in terms of spend as a percentage of gross domestic product.

Not surprisingly, Mooney's advice was not always welcomed by senior bureaucrats and ministers. Other academics - with more guile and stealth - can perhaps lay claim to more direct impact on particular policies at particular times. But his influence was far more pervasive. He influenced the criteria that define good policy and he pricked the conscience of those who would seek to hide the evidence.

In the shadow of such a man how could a young economist grow? Mooney, who personally trained many of Australia's leading health economists, was no gentle nurturer. No temperate priest. He demanded excellence of his students. They must eschew the simple and tackle the complicated instead. Against this, all other ideas and publications - no matter how impressive they might be in quantity - were derided as "workman-like". We owed it to the people who stood to benefit from our research to do better.

And so we endeavoured.

His greatest service was to berate us to extend our reach and instil in us an ethic that hopefully has been passed on to others.

Around the world now in the US, Canada, Britain, Denmark, Norway, Australia, New Zealand and South Africa there are health researchers and professionals profoundly touched by Mooney's methods and insights, his ideals and his values.

There are Aboriginal health workers now able to talk to government about "equity weightings", a metric that would give more "points" to lives saved by dialysis among people already disadvantaged. There are community groups talking about what health priorities they would meet, and what needs they would necessarily forgo, if they were put in charge of a finite regional health budget. There are health bureaucrats and professionals willing to be held accountable for the complex, but vitally important, decisions they make on our behalf.

In the tragedy of Mooney's untimely death, the only solace is for all those touched to continue to make their contribution.

Mooney, who was 69, died without any family in Australia. He and Delys Weston were buried on Thursday in Perth, Western Australia. Donations, instead of flowers, to the Schizophrenia Research Foundation.

Alan Shiell was a close working colleague of Gavin Mooney's and had known him for more than 20 years. Mooney was his PhD supervisor at the University of Sydney.

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Gavin Hunter Mooney


In May, 2012, the Australian academic Stephen Leeder spoke at the launch of Gavin Mooney's latest book, *The Health of Nations*. The author's friend and colleague saluted Mooney's commitment to social justice—“a commitment that inspires and energises and shakes us up, moves us along, and reminds us repeatedly and firmly of the higher purposes of our work”. In a career that spanned more than 30 years, Mooney's passionate and challenging style helped weave those notions of social justice thoroughly into the fabric of health economics. “He was a prophetic figure, usually contesting the prevailing orthodoxy and a valiant warrior for equity and justice”, Leeder says. “A Scot to the core, and from Glasgow to boot…his polemic and critique were modelled on tossing the caber. This was a symbol of the way he criticised, assembling his arguments like a huge wooden pole, heaving the thing up on his shoulder, running and then letting it fly until it thudded into the ground with a mighty impact.”

After graduating from Edinburgh University with a degree in economics, Mooney first became a trainee actuary at a large insurer, and then did a stint in the civil service. Apparently, the grim reality of the actuarial statistics fuelled his passion for social justice and by the mid 1970s, he had moved to his real calling—academia. First stop was the University of Aberdeen in Scotland, where he founded the Health Economics Research Unit. Then, in the 1980s, he relocated to Denmark to take up the position of Professor of Health Economics at the University of Copenhagen. Academic positions around the world followed, including visiting professorships at Victoria University in New Zealand, the University of Tromso, Norway, and the University of Sydney, Australia. Some of Mooney's seminal contributions were contained in his more than 20 books, notes Stephen Birch from the Centre for Health Economics and Policy Analysis at McMaster University, Canada. “His work on implied values, published in his book *The Valuation of Human Life* (1977)…really led to the importance of systematically including value-of-life estimates or assumptions in programme evaluation affecting risks to human life”, says Birch. “Also, his book *Economics, Medicine and Health Care* (1986)…really brought a more humanistic approach to evaluation of health care programmes.”

In 1993, the University of Sydney appointed Mooney Foundation Professor of Health Economics and he soon joined the Centre for Health Economics Research and Evaluation at Westmead Hospital. In Australia, he worked intensely on communitarianism and citizens' juries, emphasising that the values of communities should have a prominent role in determining the structure, content, and performance of health-care systems. “This is increasingly important as health care becomes increasingly technology-driven, and the divergence between the providers and the consumers increases”, says Birch.

In Sydney, and later in a professorial position at Curtin University in Perth, Mooney's work focused increasingly on health equity. He became a strong advocate for Indigenous health, and passionate about the power of citizens' juries to transform health services into social institutions answerable to the community. “His on-the-ground work with Indigenous Australians and with communities through
citizens’ juries gave his critique the legitimacy that comes only from having skin in the game”, notes Leeder. He spoke out frequently and strongly in criticism of institutions, governments, and professional bodies, and while in Perth also trained health economists from Indigenous communities.

In 2008, Mooney and his partner Delys Weston moved to Tasmania for semi-retirement. “Gavin hit the ground running in Tasmania when he arrived, writing for the media and speaking to many groups. We were in awe of having this professor in our midst”, remembers Miriam Herzfeld, convenor of the Social Determinants of Health Advocacy Network. “Gavin sought to engage with people from all walks of life and draw them into his embrace for health economics and equity in health. While he may have been a highly regarded health economist, my experience was that he was able to bring his wealth of knowledge to a level that was meaningful to everyone.” Mooney and Weston were killed in their home in late December, 2012. “We have lost a fearless campaigner and advocate for human rights”, said Australia's Minister for Health Tanya Plibersek.

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The Sydney Morning Herald

By Glenn Salkeld

Dedicated to pursuit of social justice

Gavin Mooney believed passionately in social justice and taught thousands of students in the "caring discipline" of health economics. The real power of health economics, he said, was to be found in asking the right questions: "What does the community want from their health system?", "How can we improve health unless we achieve greater equity?" and "What does equity mean anyway?"

Not one for convention, Mooney instilled in all of his many PhD students the obligation to question the status quo and to propel new ideas and methods into the discipline of health economics. Gavin Hunter Mooney was born on October 30, 1943, son of Hendry Mooney and his wife, Mary (nee Hunter), who inculcated the ideas of social justice into their children. He grew up in Glasgow, graduated from Edinburgh University in economics and became a trainee actuary. He did a short stint in the civil service but his true calling was to the academic world.

In 1977, despite not having a PhD, Mooney was appointed Professor of Health Economics at the University of Aberdeen and founded the Health Economics Research Unit (HERU). To this day HERU remains one of the leading health economics teaching and research centres in the world.

Mooney moved to Denmark in the mid-1980s, married Anita Alban and was Professor of Health Economics at Copenhagen University. He made a valiant attempt to learn Danish and his students made a valiant attempt to understand his Danish delivered with a strong Glaswegian accent. He also took up a part-time position at the University of Tromso in Norway, the world's northern most university, and developed an influential correspondence course there for health professionals.

In 1987 Mooney made his first visit to Sydney, as a keynote speaker at the annual conference of the Australian and New Zealand Public Health Association. In his opening lines, he said that Australians were a kind and friendly bunch. Then came the challenge - if we are concerned about equality in our society, particularly in relation to health, then we had better consider what we mean by equality and do something about it.

And in time Australia did so. In 1993, the University of Sydney appointed Mooney as the Foundation Professor of Health Economics and it wasn't long before he helped to establish the Centre for Health Economics Research and Evaluation, based at Westmead Hospital, where he met and later married Jackie Dettman.

He later also established the Social and Public Health Economics Group (SPHERe) in the School of Public Health at the University of Sydney and it was here that he pursued his communitarian ideology and abiding passion for Aboriginal health.

In 2000, Mooney moved to Western Australia and led the SPHERe group at Curtin University and established the WA social justice network. An outspoken critic of institutions, governments and some professional bodies, Mooney ruffled feathers and mobilised action for social justice. He also met and fell in love with Del Weston.
During his time at Curtin, Mooney trained five Aboriginal health economists - a remarkable achievement and a reflection of his commitment to Aboriginal health.

His life was run in the pursuit of social justice for people everywhere. He forged an enduring relationship with the health economics group at Capetown University and was a regular visitor to South Africa. At 67, he ran a marathon to raise money to support education for orphaned African kids. His friends and colleagues supported him with sponsorship and he raised a considerable sum of money. He was delighted when, in 2009, the University of Capetown awarded him an Honorary Doctorate as "one of the founding fathers of health economics".

No matter what the language, the culture or country, Mooney had what his colleague Steve Leeder described as a "challenging, clarifying and provocative style". He also wrote more than 20 books and more than 200 publications and held honorary positions at Aarhus University in Denmark, Victoria University in New Zealand and the University of NSW.

Gavin Mooney is survived by his family in Scotland: sister Helen, brother Grant and six nieces and a nephew. Del died with him.

This article was posted on The Sydney Morning Herald website on 11 January 2013 and is reproduced here with the permission of Fairfax Syndication.
...Testimonials collected on the ‘Crikey’ website. ‘Crikey’ is an independent online Australian news website which Gavin regularly contributed to.
A compilation of tributes to Professor Gavin Mooney and Dr Delys Weston posted on the health blog ‘Croakey’, part of the Crikey website which Gavin regularly contributed to, and reproduced here with the permission of the editor.


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A giant of a man and a true leader
Glenn Salkeld, health economist, head of the Sydney School of Public Health, University of Sydney

Gavin’s was a life lived to the full. He believed passionately in social justice – something his parents instilled in him as he grew up in Glasgow, Scotland.

As an academic Gavin didn’t waste a minute – he knew he had been given a privileged position in society and he used it to great effect. Advocating for a better deal for Aboriginal and Torres Strait Islander people, critiquing institutions that cared more for power than people and blasting those who would not listen to what the community had to say.

I will remember Gavin for many things – most notably his relentless work in educating thousands of students in health economics. Who else would set up (in 1990) a postgraduate distance course in health economics based out of Tromso University, Norway (the northern most university on the world) and expect it to succeed?

But it did succeed. I was just one of the many who signed up to the degree in the first cohort. I enjoyed every bit of the course. Gavin had a way of engaging you in intellectual debate that left you challenged but immensely satisfied.

Gavin was a prolific book writer. Here’s one story – at Gavin’s expense – that had him rolling in the aisles in laughter.

He had invited me to give a valedictory speech at his farewell from Curtin University. It was around 2007. I flew over to Perth and I remember clearly as we taxied in the plane to the gate that I mustn’t forget my iPOD and Gavin’s most recent book at the time. Both had sustained me on the 5-hour flight across to Perth.

Well, I did forget both items and duly left them in the seat pocket. I left the plane with that nagging feeling that something was missing. Once I got to the hotel it dawned on me that the iPOD and book were missing.

So I rang the airline. The lost and found chap couldn’t have been more helpful.

“What did you lose?” he said.

“An iPOD,” I replied. There was an audible intake of breath as he mentally noted that chances of getting back such a hot item were not good.

“What else mate?”


“What’s it called?”

“Challenging Health Economics, by Gavin Mooney.”

There was an audible exhalation on the other end of the phone. I could hear him thinking – no
worries on that one mate, you’ll get that back for sure.

I relayed the story to Gavin as we were driving to Curtin University. I had already written my valedictory speech and I reassured Gavin that I wouldn’t really the story at his expense. He wouldn’t hear of it – he insisted that I tell the story at his farewell. Gavin’s laugh was loudest.

The other story I’d like to share is very personal, but it says so much about Gavin.

In 1996 Tracey and I had a son, Cameron, and he died at birth. I needed to tell someone at work what had happened.

I rang Gavin. He was shocked, sympathetic and told me not to worry about a thing. And I didn’t have to. He covered all of my lectures, told all my colleagues and helped me organise a wake at our house so that all of my colleagues could help Tracey and I come to grips with our devastating loss.

If you were in need there was no better friend than Gavin.

Gavin was a giant of a man and a true leader in our discipline of health economics.

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Combining the finest of values

Dr Justin Coleman. GP, president of the Australian Medical Writers Association, and Naked Doctor columnist

Last time I was in Hobart, I caught up with Gavin, Del and her son Nick; it was delightful. The circumstances could not have been more congenial—Salamanca markets with the sun shining over our lunch spot.

The following night, they all came to watch my band play in the local pub. I publicly dedicated a song to ‘Tasmania’s ‘newest health economist’, a dedication no doubt unique in history.

Gavin and I had forged a friendship which spanned a generation gap and two sides of a continent. He taught me that one can combine the finest of values at work and at home, with the highest levels of academic and professional success.

There was no disjoint with Gavin; the qualities which made him Australia’s most respected left-leaning health economist (is any other kind worth listening to?) also made him a personal mentor to me, although he would have scoffed at the suggestion.

His Scottish congratulations was the first voice I heard upon publication of my Naked Doctor blog: he would barely have had time to finish reading it.

He was a guest in my house when he flew to Brisbane to set up the Inala Indigenous Health community jury, and in typical fashion discussed my and my wife’s work more than his.
He did have one unabashed boast, though; his beloved Del was about to complete her PhD.

The circumstances of Gavin and Del’s deaths could not possibly be more horrible, nor more contrary to the way both of them lived. It is the most unjust end to the most just of lives. I cannot dwell on it further for the moment.

Vale, Gavin and Del, and thank you both for what you gave to this earth. I would aim to live so meaningful a life.

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**A challenging, clarifying, provocative style**

*Professor Stephen Leeder, Professor of Public Health and Community Medicine, University of Sydney*

Gavin Mooney entered my life in the mid 1980s when he addressed the Sydney PHA conference entitled Just Health.

What does equity mean, he asked us? Same cash-for-health for everyone? Same opportunity for access to care for everyone? Same outcome after treatment for everyone?

His challenging, clarifying, provocative style remained during the 25 years I knew him.

Gavin’s concern was always with the ethical quality of equity, which he came to summarise in relation to health, as equal access to equal care for equal need.

He developed with other health economists including Culyer the concepts of vertical (positive discrimination for those in unequal circumstances) and horizontal equity (giving equal care to those in the same socioeconomic bracket) as applied to health.

He was a strong communitarian, aligned in many respects with Amartya Sen, and a deep critic of neoliberalism, as his last book showed.

His criticism was his strongest card: in speaking with him about his final book I asked him “What now? What can we do?” This was far from clear.

But a man of action he could be – witness his interest and work in Indigenous health and citizen’s juries.

A Scot to the core, and from Glasgow to boot, I was always surprised not to see him dressed more often in kilt and sporran. His polemic and critique were modelled on tossing the caber.

This was a symbol of the way he criticised, assembling his arguments like a huge wooden pole, heaving the thing up on his shoulder, running and then letting it fly until it thudded into the ground with a mighty impact.

I have a picture of Gavin in my head, walking the Valley of the Waters in the Blue Mountains of New South Wales with us, when our son James was two.

Gavin had him on his shoulders and James, never one then or now to miss a moment for a politically correct and endearing statement (he is now 19), kept saying, as was indeed true as we passed cascade after cascade,

‘Bootiful waterfor!’ Bootiful indeed – a memory I feel fortunate to possess.
A rare breed of academic
Statement by Federal Health Minister Tanya Plibersek

The passing of Professor Gavin Mooney and his partner Dr Delys Weston is a tragic loss for the health community, both in Australia and internationally.

Professor Mooney was a fearless advocate for social justice, and in particular the role of citizen juries, leading debates on the importance of consumers in determining how their health resources are allocated.

A ‘rare breed’ of academic, his capacity to bridge theory and practice was evident throughout his career and semi-retirement. Not only did he write the defining book on citizen juries, but then demonstrated their application in health priority setting, juvenile justice and Indigenous health. His close engagement with a number of Aboriginal Community Controlled Health Organisations exemplified his hands-on approach.

Described as ‘one of the founding fathers of health economics’, his research was driven by real world challenges and geared towards identifying practical solutions. He was an inspiring teacher and supervisor, which when coupled with his extensive publication record, will ensure his legacy persists.

Dr Weston had recently been awarded her PhD on “The political economy of global warming” from Curtin University, and held previous academic appointments at the University of Tasmania and the University of KwaZulu-Natal in Durban, South Africa.

We have lost a fearless campaigner for equity in health and advocate for human rights.

Enduring commitment to improving Aboriginal health
Statement from NACCHO

Mr Justin Mohamed, Chair of NACCHO representing over 150 Aboriginal Community Controlled Health Organisations throughout Australia, today paid tribute to Professor Gavin Mooney known as an international founding father of health economics.

Mr Mohammed said Gavin will be universally remembered for his passionate advocacy for equity and social justice at local and global levels, for his championing of citizen’s juries, and for his commitment to Aboriginal health.

“Gavin’s enduring commitment to improving Aboriginal health is what we will remember him for. He worked at both academic and community levels to assist in advancing Aboriginal community controlled health services.

He championed our call for the need for greater recognition in the funding of Aboriginal health services acknowledging that since Aboriginal health as a construct is holistic then so too should be the services to address Aboriginal ill health.

He further advocated that the issue of cultural security and the barriers that Aboriginal people face in using health services are important in any debate about funding Aboriginal primary health care.

“His support, passion and commitment to the principles and values of our Aboriginal community
controlled movement will always be remembered,” Mr Mohamed said.

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A great friend
The Aboriginal Medical Services Alliance Northern Territory (AMSANT)
The AMSANT family was shocked to learn of the tragic deaths of Gavin Mooney and his partner.
Gavin was a great friend of AMSANT from our earliest days, generously giving his time and skills to us over many years.
His work as a health economist has been of enormous value to the Aboriginal Community Controlled primary health sector, bringing new insights and perspectives to the work we carry out in our health services, from urban to remote bush settings.
AMSANT extends our condolences to Gavin’s friends and colleagues. He will be greatly missed.

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The loss of a champion
National Rural Health Alliance
The Australian health sector has lost a great intellect, advocate and human being.
People living with disadvantage, whoever they are and wherever they live, have lost a true champion.
Many people have lost a colleague and friend.
And the manner of Gavin’s death, and that of his partner, makes these losses all the more shocking and tragic.
The NRHA extends its heartfelt sympathy to the families involved.
All of those determined to right inequities will have to work a little harder in the absence of Gavin’s support. But hopefully they will be a little more inspired by the lasting memory of his work and the manner in which he achieved it.

***

Moral values informed his research
Associate Professor David Thomas, Lowitja Institute
The Lowitja Institute is saddened by the tragic deaths of Gavin Mooney and his partner Del Weston in Tasmania on Wednesday.
Gavin introduced the rigour of health economics research to debates about fairness and Aboriginal health.
Over the years he made many significant academic contributions to our understanding of health equity and inequity in Aboriginal health. His research was always informed by his clearly articulated moral values.
He never just described the problem. His research and his public health action and advocacy were forever entangled.
He was always working with others to find new solutions to improve health equity and social justice for all.
Gavin was a passionate and committed colleague, and an enthusiastic mentor to many Aboriginal and non-Aboriginal colleagues. He was also great fun to be around. In particular, I remember one night after a long meeting in Alice Springs in the 1990s. We were on the back of an old train, with Gavin telling his funny, crazy stories and the laughter spilling into the desert night. He will be missed greatly.

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**A powerful voice on the social determinants of health**

*Statement by Dr Richard Di Natale*

I wish to express my personal condolences, and those of the Australian Greens, to the family of Professor Gavin Mooney and Dr Delys Weston.

I was filled with great sorrow this morning when I learned that Professor Mooney and Dr Delys Weston had been tragically killed.

As a doctor and public health professional I followed Professor Mooney's work with great interest and after entering the Senate I discussed with him some of the challenges facing Australia’s health system.

He was known around the world as the father of health economics but his contribution to public health did not end there.

He was a powerful voice on the social determinants of health, on Indigenous health and on the impact of doctor shortages in Australia and in developing countries.

I learned a great deal from Professor Mooney and he will be sorely missed. Fortunately the legacy of his contributions to public health will continue to guide us for years to come.

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**An enormous contribution to health policy**

*Dr Tony Hobbs, GP and primary health care reformer*

Gavin Mooney has made an enormous contribution to health policy in Australia.

His unstinting support of social justice and equity issues has been critical in encouraging policy makers to think of these issues.

In particular, his support of Primary Healthcare Organisations as a vehicle to reduce health inequity in this country & his idea of citizens’ juries as a means of harnessing broad community involvement in their development has been very important.

He will be sadly missed.

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**A generous and prolific contributor**

*Graeme Lynch, CEO of the Heart Foundation Tasmania, and also as Chair of the Health in all Policies Collaboration*

The members of the Health in All Policies Collaboration are jointly grieving the death of friend,
mentor and international champion for health equity, Professor Gavin Mooney.

In his short time living in what had become his “beloved Tasmania”, Gavin provided great inspiration and leadership to us both individually and collectively in championing the imperative for new equitable approaches by governments … “to serve the public whose health is at stake”. Gavin’s views challenged all our thinking.

Gavin and I became good friends and he was a great “mentor” on health equity: addressing members of the Premier’s Physical Activity Council and also members of the Health and Well Being Advisory Council, the Tasmanian Health Conference (facilitated by the AMA), the TasCOSS Conference and many others. He was also advising the Tasmania Medicare Local for whom he facilitated a Citizen’s Jury on after hours service, and had advised on a range of health equity issues.

He attended both the inaugural meeting of the TML SDoH and Health Risk Factors Steering Committee (established as one aspect of the Commonwealth’s Tasmanian Health Assistance Package) and the Tasmanian SDoH Advocacy Network open forum at the Hobart Town Hall in the week before his untimely death.

Gavin was behind the development of the SDoH Advocacy Network and also volunteered at the Menzies Research Institute.

He was also a regular contributor to public debate through the Tasmanian press, Croakey and his writings and commentary more widely. His contributions to the Tasmanian Joint Parliamentary Select Committee on Preventative Health Care (including SDoH), that was established in November, were eagerly anticipated.

The Heart Foundation in Tasmania is taking a national lead in the equity theme in our latest five year strategic plan For all Hearts, and Gavin gave very generously of his time to assist our Health Director, Gillian Mangan and me in developing our thinking, and in providing us with stimulating discussion and referral to international research and thinking.

He was always talking of his concern for Aboriginal and Torres Strait islander peoples and the fact that land and culture are the most important social determinants in Closing the Gap.

His views on the need to tackle the entrenched vested interests he identifies in the Introduction to his most recent book “The Health of Nations”, provide a challenging construct based on his perception of the inequities, most importantly power, that act as barriers to obtaining the best health and well being outcomes in all societies including Tasmania.

He challenged the neoliberal philosophies espoused by Prime Minister Thatcher and President Regan and questioned the limitations of laissez-faire economics and structures – all of which can work well if the “Spirit Level” is even.

Most importantly, and what I learned personally from him, was his ability to listen and understand the local context and then impart his views in a non-prescriptive way.

Nonetheless, I did hear him on few occasions challenge some very tall poppies very effectively and without fear!

Whilst providing a donation support to me last month in a charity bike ride from one end of the State to the other, he wrote: “Good luck on the ride! I ran a marathon 2 years ago with financial backing from friends to support refugees in South Africa. I know that I would not have finished without that
It is so sad that we lost Gavin when he still had a few more “marathons”, both physically and intellectually, ahead of him.

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So many qualities to love and admire
*Siobhan Harpur, Director Population Health Operations/Health and Wellbeing, Department of Health and Human Services, Tasmania*

Gavin Mooney and Del Weston were only with us in Tasmania for a brief time, but they leave a legacy that I hope will challenge us all personally and professionally.

They were convinced that a fair and better world was possible and he and Del lived passionately by example, treating everyone they met on a level playing field.

Gavin provided advice to the Ministerial Council for Health and Wellbeing and Population Health staff in our work to improve health and Wellbeing for all Tasmanians.

He was instrumental in establishing the network for the social determinants of health, and in assisting the Tasmania Medicare Local with its funding for the determinants.

He would remind us all so often, in his quiet yet persistent way, that we needed to listen to citizens and not just think we know what people wanted without asking them first.

He had championed citizens’ juries, but this was only an example of a much stronger personal conviction to give people more control in their own lives. He described himself as a communitarian and there were so many qualities to love and admire of these fiercely gentle folk.

Let me find the courage and strength for their lives to continue to speak through my own humble commitment to tolerance, justice and equity.

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Passion for a more equal society
*Miriam Herzfeld, Convenor, Social Determinants of Health Advocacy Network (Tasmania)*

Gavin told me to “trust in yourself and in your principles”. It was these principles that brought us together to advance action on the social determinants of health in Tasmania for a short period of time.

Gavin was passionate about creating a more equal society – a society in which we all have the opportunity to lead healthy lives filled with opportunities regardless of who we are or where we live. We shared this passion.

Gavin also told me that, “It is at times a really shitty world… but that there are some truly wonderful inspiring people”. And dear Gavin, you are one of those inspiring people.

I am blessed to have known you. Thank you for your mentorship, your friendship, sharing your passion and igniting a movement in Tasmania that will go on in your honour.

To the lovely Del, thank you for your contribution to the Social Determinants of Health Advocacy Network too, and for your generosity and friendship.

***
Important work must be carried forward

Carole Owen, Deputy Director, Population Health, Department of Health and Human Services, Tasmania

What a tragedy. Even though Gavin had only been in Tasmania for a relatively short while, he had already made so much different to the way we think about improving health and wellbeing for all.

His ability to bring people together and inspire us all made us feel that we could make a difference, and that the world could be a fairer and better place.

We have lost a creative thinker, a passionate advocate, a great friend and a gentle man in the true sense of the word.

It is up to all of us to carry on his important work.

There are no words to say how much we will miss him.

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Tribute from the marathon running community

Dr Jo Clarkson, Director, Health Promotion, The Western Australian Health Promotion Foundation

My personal memory of Gavin and Del is perhaps a little different from all the many tributes that will no doubt come in from professional colleagues.

Although I too was inspired by their energy and enormous commitment to health equality and social justice, I came to know them in recent years through the marathon running community in WA. This is a dedicated bunch of people from all sections of society, united by their love of running.

Out on the road with fellow runners and shared stories of the last marathon or the latest injury, no one cares if you are beggar or a millionaire, and academic qualifications count for zero. There is a great camaraderie among distance runners and the Sunday morning and Wednesday evening club runs are regular social gatherings.

Five or so years ago while marshalling at the finish line of one of our Sunday morning club races I found myself talking to Del, who said she was waiting for her partner to finish the race. She started to tell me about her PhD on the politics of climate change and I was intrigued by her work.

We hit it off straight away and I had no idea who she was or that her partner was Gavin Mooney until, completely engrossed in our conversation, we almost missed Gavin’s moment of triumph as he crossed the finish line! Of course I recognised him as soon as I saw him.

From then on, every time I saw Gavin he would report on how his training was going and tell me about his plans to run another marathon following his so-called ‘retirement’. Their tragic and untimely passing is a huge loss.

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So few thinkers of his calibre

Ian McAuley, Fellow, Centre for Policy Development

Of course we are left deeply shocked. As senseless as the Newtown massacre, as the murder of public health workers in Pakistan, as the rape of a 23 year old student who should have a whole exciting world ahead of her.
There are so few thinkers on health policy who combine independence, perspective and a clear logical framework – be that neoliberal, Marxist, distributionist, socialist or whatever other political-economic framework is competing for our attention.

We need such thinkers, and there are so few of them. In those qualities Mooney stood head and shoulders above all of us.

Below is an extract from an E-mail I have just this morning (Friday, 21 Dec) sent to Cathy Alexander (Crikey’s deputy editor):

“….you would have heard about the senseless murder of Gavin Mooney. I hope you can publish a few words about him. I have just had published, in Dissent, a review of his latest book *The health of nations: towards a new political economy*. It’s a challenging work, critical of the way we tend to tinker at the edges of what he saw as a flawed system. Before coming to our country he grew up in the misery of Glasgow in the years following Europe’s 1939-45 war – that experience was certainly formative.”

I don’t know if he saw the review before he died. Dissent came out only on Wednesday.

My final words in that review were:

“Perhaps the sort of social transformation Mooney seeks will eventuate, but none of us will be around to see it occur. There are many Marxists who believe that capitalism has some way to run before it collapses on its own contradictions – the revolution of 1917 was a few hundred years too early and in any case Russia was still feudal rather than capitalist.

In the meantime, while we await the revolution, his work is a stimulating contribution to our thinking on health policy. In its obituary column in early October The Economist referred to the historian and philosopher Eric Hobsbawn as “the last interesting Marxist”. It appears they were not aware of Gavin Mooney’s work.”

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A deeply felt loss
ACOSS

ACOSS and the COSS network have been deeply shocked and saddened by the deaths of Gavin Mooney and Delys Weston.

Gavin Mooney was a Health Policy Advisor to ACOSS from 2008-09 and an incredibly important contributor to our policy work in health.

Gavin lent his standing as a world-recognised figure in health equity and economics to the work of ACOSS and was a staunch supporter of all ACOSS stood for.

His reforming work in the areas of Aboriginal health, citizen engagement and on the social determinants of health; and both Gavin and Delys’ contribution on the important intersections between health and climate change are particularly well-remembered across our network.

This is a loss felt deeply by current and former staff, Policy Advisors and members of the network of Councils of Social Service in Australia.

***
A champion of equity
WACOSS

On behalf of community service organisations throughout WA, committed to a vision of an inclusive, just and equitable society, the WA Council of Social Service expresses its profound shock and sadness at the terrible death of Professor Gavin Mooney, together with his partner Del Weston.

Professor Mooney was well known and regarded by the community services sector as a champion of equity.

His contribution to social policy debate was courageous and immense, driven by a deep felt commitment to social justice.

Long recognised as one of Australia’s leading health economists, Professor Mooney placed equality, human rights and the legitimacy of community expectations at the centre of public policy.

Professor Mooney’s personal passion for Indigenous health and justice will be long remembered.

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His work will live on
Dr Rachael Morton, Senior Research Fellow – Health Economics, Sydney School of Public Health, University of Sydney

I first met Gavin when he became a mentor to our new team of health economists at the University of Sydney in 2008.

I had read many of his texts and was drawn to his focus on the causes of health inequity including power, gender and social class, and the use of citizen’s juries for resource allocation.

At times he seemed more of a philosopher or sociologist then an economist. His lectures were well researched and forthright. He pushed the boundaries of conventional economic thinking. He was tireless in his campaign for social justice and grass roots ‘community’ decision-making.

At the last International Health Economics Association (IHEA) meeting in Toronto in 2011, he reminded us to pursue health economic research that would help the disadvantaged not the advantaged, particularly those in low and middle income countries.

Gavin’s energy, passion and leadership will be sorely missed – but his message will not be lost on a new generation of health economists.

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An enduring impact
Dr Raquiba Jahan Khan, mental health promotion officer, NSW

It is a great loss. Gavin was the Post Graduate Course Coordinator while I applied for PhD (1996, supervised by Don Nutbeam) and for the scholarship.

I received his support in the process of both applications. The following five years I had opportunity of discussing with him about issues and concerns, I sought his advice every now and then. I am grateful to him and I will be remember him for whole of my life. May God grant him and his partner Delys Weston eternal peace.

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Not one for lazy convention

Joel Negin, senior lecturer in international public health at the University of Sydney

I didn’t know Gavin all that well but the times that we did meet, he made a very strong impression on me.

I first met him 3 or 4 years ago and he was serving as a mentor to a group of health economists at Sydney Uni. Having someone there who shared my international interests was special and, more importantly, it was amazing to have someone there so committed to social justice, to strengthening communities, to ignoring lazy convention.

He knew that health economics was part of a larger whole of equity and wasn’t just a narrow technical science. I had a few long conversations with him and learned a great deal from him in a short time.

He made sure I knew that pursuing a career in global social justice from Australia was not just possible but necessary.

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Other tributes and reports:

• At the Green Left:

“Del and Gavin were as kind and loving in their personal dealings with everyone they met as they were committed to the liberation and freedom of all humanity. They were strong supporters of Green Left Weekly; making regular donations, hosting fund-raisers and recently making a significant contribution to the new Green Left TV project.

Gavin and Del were also keen to share their areas of professional academic expertise with activists. We remember their presentations at our 2010 Socialist Ideas seminar; Gavin on the campaign for properly funded and managed public health care, and Del on the impact of global warming on the poor in Africa…”

• The National Tertiary Education Union

“Before semi-retiring in 2008 and moving to Tasmania, Professor Mooney, 69, had been Director of the Social and Public Health Economics Research Group and Professor of Health Economics at Curtin University in Perth. He was a very active member of the National Tertiary Education Union (NTEU) from 2003-2009.

Jan Sinclair-Jones, NTEU Curtin Branch President, said that Professor Mooney was very highly regarded both as a scholar and person.

“Professor Mooney was Australia’s leading health economist and a ‘founding father’ in this newish field internationally – an achievement recognised by the University of Cape Town which awarded him an Honorary Degree in Social Sciences in 2009,” she said.

“He was passionately interested in the impact of poverty and inequality on health and worked at both the university and community level to foster Aboriginal control of Aboriginal health services. Gavin was active in establishing the WA Social Justice Network. Since moving to Tasmania last year, he’s contributed to The Mercury’s coverage of health issues.”
Sinclair-Jones said that Professor Mooney had been a good friend and she was personally shattered by the tragic news.

“Gavin was a lovely person – funny, engaging and a great colleague. He was a fearless champion of justice and totally brave when it came to speaking out to the media. He was much admired by those who worked around him and could always be relied upon to be on the picket line. We will miss him profoundly,” she said.

His partner, Dr Weston, 62, wrote her PhD on the political economy of global warming at Curtin University. She had been a visiting Scholar at the University of KwaZulu Natal in Durban, South Africa and an Honorary Research Associate at the University of Tasmania in the School of Geography and Environmental Science.”

A generous spirit
Statement by Australian Healthcare & Hospitals Association

The Australian Healthcare & Hospitals Association (AHHA) expressed its shock and deep sadness at the death of Professor Gavin Mooney and his partner Delys Weston.

The Australian Healthcare & Hospitals Association represents Australia’s largest group of health care providers in public hospitals, community and primary health sectors and advocates for universal high quality healthcare to benefit the whole community.

“Gavin was one of Australia’s leading health economists who used his knowledge and skills to improve the lives of the disadvantaged in Australia and around the world,” Ms Prue Power AM, CEO of the AHHA, said today.

“Gavin was a health economist who saw beyond the dollars and cents to the real life impact of illness and disability on both individuals and our society as a whole. He had a particular passion for Indigenous health and worked with governments and Indigenous communities to improve health outcomes among Aboriginal and Torres Strait Islanders by addressing the social, cultural and economic determinants of health.

“He was a strong advocate for consumer-driven health reforms and had particular expertise in Citizens’ Juries, a process for enabling consumers to determine priorities for health funding. Gavin had written extensively on Citizens’ Juries and personally conducted a number of these around Australia and overseas. His commitment to this issue and his generous spirit prompted him to make his book on this subject available without cost, to ensure that it was accessible to everyone in the health sector.

“AHHA’s Just Health Consultants had been working with Gavin on a project and will greatly miss his insightful and knowledgeable input. In countries as diverse as South Africa and Finland, as well as in Australia, his contribution to improving the health and well-being of our communities will be sadly missed.

“AHHA would like to extend our sympathies to Gavin’s and Delys’s families at this tragic time,” Ms Power said.

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Passionate concern for the health of South Africans

Ginny Stein, ABC Africa correspondent

Gavin contacted me earlier this year saying there was one issue he felt strongly about and would I be interested in following it up.

We talked about wealthy nations like Australia poaching doctors from poorer nations and the impact it was having. Through his wealth of contacts in South Africa I was put in touch with people who were willing to speak about an issue that is having a devastating impact on the lives of many South Africans.

I met and interviewed Gavin when he came to Johannesburg. It was both a pleasure and a joy.

After the story went to air, he had stayed in touch discussing this issue and others, his passion and conviction unwavering.

Passionate about priority setting

Gai Moore, Manager, Knowledge Transfer in the Knowledge Exchange Program at the Sax Institute

Gavin had just completed work with us on one of the topics he was passionate about – priority setting in health. It is a rapid review of the evidence on priority setting methods that support the key design principle of ‘Efficient and appropriate allocation of resources where they can do most good on the basis of models of best practice which deliver best health outcomes’.

As part of writing the review, Gavin interviewed leading health economists from around the world (Australia, The Netherlands, Sweden, United States, Scotland, England, Denmark, Wales, and Canada). They and others might like to know he finished the work and that their contribution was included in his report (Mooney G, Angell B, Pares J. Priority-setting methods to inform prioritisation: an Evidence Check rapid review brokered by the Sax Institute for the NSW Treasury and the Agency for Clinical Innovation, 2012).

Gavin was my first economics lecturer in the early 90s at Sydney Uni and he put us through several priority setting exercises – keen that we both understood his values and recognised our own – and that we understood how these influence decision making.

Equity was his driving passion. In his own words: “How else would you spend your life?”

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...A selection of articles from a Special Issue of the journal *Social Science and Medicine*, published in May 2014 as a tribute to Gavin.

The journal is available online at:
http://tinyurl.com/GavinMooney
Introduction

Inclusiveness and health economics: Reflections on the work of Gavin Mooney (1943–2012)

In late December 2012, the world of health economics was shocked to hear of the death of Gavin Mooney and his wife Delys Weston at their home in Tasmania, Australia. Mooney was a leading member of a brilliant generation of economists who in the 1970s defined and developed health economics as a new field of academic inquiry. He was a long-time contributor to Social Science & Medicine as an author, reviewer and advisory editor.

Following his death, traditional and social media as well as other academic journals paid testimony to how Mooney’s work had been influenced by his upbringing and his infectious and fiery personality. As one of the leading health economics educators this personality stimulated others to make major contributions to the growth and content of the discipline, and influenced many in leading health policy positions in various countries.

To complement these tributes Social Science & Medicine chose to produce a collection of academic papers that reflect on Mooney’s contribution to the health economics discipline. Authored by colleagues who worked closely with him and were at some stage of their career mentored by him, the papers discuss how Mooney significantly advanced different areas of health economics. They identify the contribution and impact of his ideas as well as the issues that remain unresolved and form an agenda for others to follow, both today and in the future. Given Mooney’s capacity building prowess, this is a legacy that Mooney would have loved.

In such a small collection of papers we cannot do justice to the full range of Mooney’s contributions. Instead we have deliberately focussed on concepts Mooney identified and developed in his contributions to Social Science & Medicine. The overriding theme is ‘inclusiveness’, reflecting not only his personality and generosity to others but also his approach to working on disciplinary interfaces. Inclusiveness represented to Mooney an approach from which health economics and health economists could learn, to which they could contribute, and, as a result of which, develop and extend their methodological toolbox. Each of the papers that follows incorporates this theme.

Ryan and Gerard discuss Mooney’s contributions to conceptual debates and empirical work on the objectives of health care interventions from the perspective of individual clients and patients. Mooney argued that health care interventions offered patients more than just health outcomes, applying his arguments to breast cancer screening (Mooney, 1982) and ante natal screening (Mooney & Lange, 1993). This extended to challenging health economists to supplement their efforts to improve the validity of the measurement of benefits by broadening the scope of measurement to accord with what people wanted from their health care systems (Mooney, 1994). Although this area of empirics is often dominated by normative arguments, we are only beginning to recognize the positive implications of these normative debates in terms of impacts on adherence with treatments, the efficiency and equity of health care resource use and health care system performance.

In their papers on ‘inclusiveness in the value base for health care resource allocation and in health care decision-making processes’ Jan and Wiseman show how Mooney takes these debates further and wider. Outcomes (and in particular health outcomes) have become the modus operandi for clinical researchers and many extra-welfareists and the decision makers and policy analysts that these academics advise. Yet individual clients and patients will be influenced by, and concerned with, impacts on other aspects of well-being, including the processes through which health and other outcomes are generated. Irrespective of whether decision makers’ deem health gain to be the appropriate outcome for ‘judging’ performance or determining resource allocations, individual behaviour responds to these individual goals. Taking the debate further, Mooney (1998, 2005) argued that communities or societies may expect more from their public institutions than maximizing health gains and introduced aspects of community and communitarianism into debates about the design of health care systems and decision making processes as a means of addressing, amongst other things, social equity (Jan, Dommermuth, & Mooney, 2003). Jan notes the discrepancy between Mooney’s arguments for using the objectives of individuals (as opposed to providers and decision makers) in evaluating services but rejecting the objectives of individuals in evaluating health care systems. The need, as Mooney saw it, to reflect ‘community’ preferences, through which minority interests may (but of course need not) be incorporated, gives rise to issues of what defines a ‘good community’ and what is to be done in cases of ‘bad’ communities (the ‘Not in My Back Yard’, or NIMBY, problem).

These same issues are then addressed on a more global stage through McIntyre’s piece on ‘Inclusiveness and involvement in public and global health issues’. Mooney’s ideas took on the issues of marginalised populations in an increasingly globalised world unable or unwilling to respond to the particular needs and circumstances of marginalised or simply atypical populations (Mooney, Jan, & Wiseman, 2002). He argued that global economic trends and powers have major influences on our health care systems and on public health in ways that we may not wish for. But again, who are ‘we’ and ‘our’, and what actions and impacts might arise?
These are questions that Mooney raised, in some cases addressed, but also left as part of a future agenda for others to take forward. Mooney’s legacy is reflected in what he left behind. His inclusive approach has opened up many areas for further study by his health economics colleagues. This future work will further develop the health economics discipline, health economists and global health research. We believe he would see this as more important than his own immense achievements.

References


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Inclusiveness in the health economic evaluation space

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ABSTRACT

This paper presents an overview of Gavin Mooney's contributions to broadening the evaluative space in health economics. It outlines how Mooney's ideas have encouraged many, including ourselves, to expand the conventional QALY/health gain approach and look more broadly at what is that of value from health services. We reflect on Mooney's contributions to debates around cost-effectiveness analysis, Quality Adjusted Life Years (QALYs) and cost-utility analysis as well as his contribution to the development and application of contingent valuation and discrete choice experiments in health economics. We conclude by suggesting important avenues for future research to take forward Mooney's work.

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"Preferences are preferences — economic theory is not supposed to pass moral judgements about what should be in a utility function"


Introduction

Gavin Mooney had an enormous impact in health economics. His endless energy, enthusiasm, commitment to challenge, concern for communities and social justice, and dedication to mentoring young health economists has left a legacy in health economics that will live on for a very long time. Mooney's research interests had breadth and depth. As one of the founding fathers in health economics, Mooney is credited with playing a hugely influential role in the development of health economics thinking, methods and applications. This paper considers Mooney's contribution to the inclusiveness of the evaluation space in health economics, using key papers published in Social Science and Medicine (SSM) during the 1980s and 1990s. During this period Mooney believed that many economic evaluations were limited in scope. More specifically, he argued that there was a need to value all that matters in the utility function, not just health outcomes. And that it was the values of patients and citizen's that mattered, not doctors or economists. He also questioned the use of QALY league tables for decision making, and challenged the assumption that a "QALY is a QALY." This paper has a historical structure, highlighting how Mooney's ideas developed over time and contributed to valuation in health economics today. The paper naturally splits into 3 sections: cost-effectiveness analysis; Quality Adjusted Life Years (QALYs) and cost-utility analysis; and contingent valuation and discrete choice experiments. Finally we reflect on the impact, both academic and on policy, of Mooney's work challenging the valuation space; the implications of the different normative approaches to valuation; and important future research to continue the development of valuation in health economics.

Cost-effectiveness analysis

The early days of health economic evaluations saw cost-effectiveness dominate - here costs are measured and compared with some unidimensional measure of outcome, usually clinical in nature, e.g. number of cases detected or life-years gained. Mooney's early cost-effectiveness work challenged the inclusiveness of the economic evaluation space. For example, in his early study of breast cancer screening. Mooney questioned what resource costs should be considered and who the beneficiaries of such screening were (Mooney, 1982). Costs of women's time and travel were estimated - at that time it was unusual for a cost-effectiveness study to include non-NHS costs. NHS costs for women screened positive and biopsied and women found negative falsely and biopsied were estimated, another deviation from standard practice. Mooney drew attention to differences in sensitivity and specificity of screening associated with different screening regimes and the importance of taking account of the value of all screening outcomes. He concluded:

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"a better criterion of efficiency is the ratio of false positives/true positives".

p. 1282.

Later work developed these ideas. Gerard, Turnbull, Lange, and Mooney (1982) identified 6 groups potentially affected by such screening. For those who attend screening groups are: "true positive", "true negative", "false positive", "false negative". True positives are women who have been correctly identified as having breast cancer. They are the usual focus of economic evaluations (or were at this time). True negatives represent the majority of women screened who do not have breast cancer. Whilst the results of screening do not alter their health, they may benefit from reassurance. Women who receive false negatives may later have higher levels of distress and anxiety because of earlier reassurance. False positives will experience anxiety and fear of a possible diagnosis as well as further investigations until the diagnosis is excluded. Then there is concern for two groups who do not attend for screening. First those not eligible but who know of the existence of the screening programme may feel worse off as a result of the programme's existence. They feel 'deprived'. Second those who choose not to attend might later regret such a decision. Thus benefits are not restricted to the screened population. Later research explored how screening outcomes for participating women can be valued (in a cost-utility framework) (Johnson, Brown, Gerard, O'Hanlon & Morton, 1998). The study assessed the feasibility of adapting the time-tradeoff methodology to link temporary and chronic health states.

Mooney also questioned the narrow definitions of benefit when valuing antenatal screening, criticising the common assumption that the benefits from screening arose only from the termination of an affected foetus (Mooney & Lange, 1997). He noted that significant proportions of women attending antenatal screening programmes would not terminate their pregnancy if the test was positive and raised the question of why these women were choosing to be screened. Clearly there were other benefits from screening, such as information and reassurance, which should not be ignored. He also argued it was important to consider dis-benefits such as regret and anxiety arising from the uncertainty attached to test results. Mooney argued that the starting point ought to be looking more closely at what is in the (woman's) utility function:

"Presented from the woman's point of view, there seems no argument against using the true contents of the woman's utility function. How one might sort about getting the relevant agents to include all of the arguments is however less than clear. Perhaps that is the subject of another paper."

p. 877.

Quality adjusted life years (QALYs) and cost-utility analysis

The mid-80s saw the development of QALYs, 'QALY league tables' and cost-utility analysis (cost per QALY) in health economics. Whilst recognising the value of QALYs in raising awareness of the need for a transparent framework for priority setting, Mooney indicated that health is not the only argument in the utility function, and that QALYs were too narrow a measure of value (Mooney, 1989). He was keen to make clear the limitations of the QALY league table as a method for guiding decisions on resource allocation: relevant only to health care decision makers concerned with allocating resources within a health care budget and whose objective is to maximise QALYs (Gerard & Mooney, 1993). His SSM editorial "What else do we want from our health services? challenged the QALY approach to valuation, both because of its narrow definition of value (health), and its failure to ask the public what they want from their health care system (Mooney, 1994):

"Many of the factors encountered in the process of care — getting information on when the operation will take place, having a cheery nurse by the bedside, avoiding the 'gang no' anaesthetist or the condescending or patronising junior doctor, having one's autonomy respected — are all aspects of care that can improve on patient utility other than on health."

p. 152.

He went on to argue that it was not for economists or doctors to define what is in the patient's utility function.

"Let us find out through some appropriately designed surveys first, what patients want from their health service and second, what people as citizens went from their health service".

p. 152.

Mooney further argued that if 'what patients' want is sometimes different from what citizens want, the hierarchy of legitimacy of wants (as he put it) will normally be such that citizens' wants will prevail:

"It is difficult to see with whom a higher authority could lie. This is not a matter for the value judgements of the medical profession. This issue is not technical concerning 'medical' matters; it does not require doctors to act as "agents", it is a social matter."

p. 152.

Whilst this was probably a precursor to Mooney's developing interest in other areas of health economics (i.e. equity, community participation and claims, Aboriginal Health), it was also a powerful message within the health economic evaluation community. A lot more attention was needed concerning investigation of social versus patient values. This is currently an under researched area in health economics, though almost ten years later the importance of social values is being increasingly recognised (Brazier et al, 2011; Lancer, Willman, Donaldson, Ryan & Baker, 2011; Linley & Hughes, 2013; Norman, Hall, Street, & Viney, 2013; Shah, Tscharhi, Hole, & Wallace, 2012, Shah et al, 2012).

Related to the above point, Mooney also questioned the assumption that a QALY is a QALY, i.e. the value of a QALY is fixed, regardless of who receives it (Mooney, 1989):

"Another relevant issue here is that the way in which QALYs are intended to be used assumes that when we have QALY gains it does not matter who gets them, they all count equally. QALYs normally state this explicitly although there is nothing in the methodology of QALYs which means that we necessarily need to hold to that assumption. It could be varied although usually it is not. This is a very strong assumption. It means that if there are differences in the utility attached to health gains across different individuals then the idea that QALYs were the only argument in the patients' utility functions, we would not maximise utility even if we did maximise health gains.

p. 104.

This continues to be an important debate in academia and the policy arena. For example, Dolan et al. (2004) reviewed the academic literature, showing that members of the public do not
support the view that a QALY is a QALY. At the policy level, there have been changes in the way NICE evaluates medical treatments for patients who are in the last stages of their lives. If medicines are for “end of life” care, NICE gives higher weight to QALYs gained (NICE, 2009). Implied is a QALY is not a QALY. The move to Value Based Pricing implies that QALYs are not of equal value — consideration will also be given to burden of illness (the combination of unmet needs and disease severity), therapeutic innovation and the wider societal benefits a treatment offers (Department of Health, 2010b).

**Contingent valuations and discrete choice experiments**

There is no doubt that Mooney’s questioning of the valuation space within both cost-effectiveness analysis and QALYs/cost-utility analysis influenced the development and application of contingent valuation (CV) and discrete choice experiments (DCEs) in health economics. Both CV and DCEs were applied in the early 1990s to go beyond QALYs and take account of process utility in the valuation process (Donabedian, 1995; Ryan, 1995). These two instruments have now become standard instruments for valuing benefits in the health economist’s toolbox (de Bekker-Grob, Ryan, & Gerard, 2012; Donabedian, Mason, & Shackley, 2012). Both have been extensively used to value broader aspects of value in the delivery of health care. For example, in early applications of CV and DCEs in health economics, Ryan (1997, 1998; 1999) valued broader aspects of value in the provision of infertility services. These studies confirmed that infertile couples cared about more than the clinical outcomes, and that the process of care and psychological feeling of regret was a motivator in decisions to undertake IVF. More generally early application of CV and DCEs considered health care about: the process of care, and non-health outcomes such as provision of information and reassurance, and that both CV and DCEs are useful instruments for valuing such factors.

Recent work has questioned the focus on process utility (a term that has become synonymous with patient experiences). Entwistle, Firth, Ryan, Francis, and Kinghorn (2012), in developing a conceptual map of what is wanted by the patient experience, argue that it is important not just to consider the process of care (the left hand side of their conceptual map), but also how health services enable individuals to be the best they can be (the right hand side of their conceptual map). A review of the application of economic methods to value patient experiences in the delivery of health care found that CV and DCEs have been extensively used to value process aspects of care such as: location of treatment; travelling time/distance to clinic/appointment; cost of travelling; waiting time for an appointment/on a waiting list; whether the member of staff seen is familiar/continuity of staff seen; length of consultation; privacy (when receiving test results) (Ryan, Kinghorn, Entwistle, Francis, & Firth, 2014). The authors note the need for the valuation space to be extended to take account of aspects of the utility function that relate to enabling individuals to be the best they can be.

While being developed to value process utility, DCEs have also been used to address other important questions within the valuations space (de Bekker-Grob et al. 2012). These include valuing health outcomes that would not be captured in the QALY, the trade-off between health and non-health outcomes and estimation of probabilities to predict uptake of new drugs and interventions. Interestingly, the DCE method has also been used to look at both societal values and to question the assumption that a QALY is a QALY. Issues that Mooney was concerned with. For example, Brazier et al. (2013) used DCEs to look at societal values within the debates around Value Based Pricing and Shah, Tsuchiya, et al. (2012) used DCEs to examine public support for the NICE end of life supplementary guidance.

DCEs and CV are not without their limitations. A key concern is the extent to which responses reflect real behaviour, resulting in many economists being sceptical about the use of such methods. The issue of external validity has received little attention, perhaps reflecting the difficulty of setting up experimental tests. The limited work available has focused on CV, with mixed results (Bhatia & Fox-Rushby, 2009; Bryan & Jowett, 2010; Starfield et al., 2008; Starfield et al., 2009). Similarly, I compared the elicited hypothetical values to a fixed price real purchase, limiting their research question to whether these values were higher than the actual value purchased, instead of whether the stated actual price was paid and, between sample field experiment on management of health conditions (asthma, diabetes and mental health programs), comparing stated and actual willingness to pay, have reported evidence of hypothetical bias (Blume-Bey, Blume-Schonfels, & Johannessen, 2009; Blume-Schonfels, Blume-Schonfels, Johannessen, Horn, & Freeman, 2008; Blume-Schonfels, Johannessen, Yokoyama, & Freeman, 2001), while use of verbal and or numeric certainty scales reduces such bias. In the only study in health looking at the external validity of DCEs, Ryan and Watson (2009) compare hypothetical and actual responses within a DCE and found that 80% (n = 90) of respondents answered the same way in the hypothetical and actual choice. This study was limited in that a price proxy was not included. Further work on external validity is clearly needed.

**Reflections**

So what has the impact been of Mooney’s work on the valuation space in Health Economics? At an academic level his thinking has shaped the development of the discipline, feeding into the development and application of DCEs and CV to go beyond health outcomes. Whilst QALYs do currently dominate the valuation space at the policy level internationally, the importance of considering broader aspects of value in health care policy. For example, NICE has accepted that the QALY is not appropriate for valuing treatment at end of life (NICE, 2009) and accepted that need to move to monetary measures of CV and DCEs in the evaluation of public health interventions (NICE, 2012). Further, the introduction of Value Based Pricing for drugs, where drugs with a higher burden of disease will carry a premium, implies not all QALYS are of equal value (Department of Health, 2016b).

In summary, Mooney’s work around the valuation space in health economics stressed the importance of knowing the nature of the patient’s utility function — it was not for economists or doctors to define this, but for patients and the community. Mooney was proposing a different normative position to that proposed by proponents of the QALY (who see the goal of health services being to maximise health). These different normative approaches are important, having implications for how our health services are provided, which in turns will affect factors such as compliance, equity and efficiency. Further, we know that health services fall well short of what is considered acceptable (Francis, 2010, 2013). Mooney’s focus on the nature of the utility function and the importance of patient and community led health services is not simply normative, it is crucial if we are to provide the patient centred care that is currently promoted in policy documents (CAHPS, 2013; Department of Health, 2010b; Scottish Government, 2010; The National Health Service, 2013). Health Economics, and wider society, has suffered a tremendous loss by the tragic death of Gavin Mooney. His contribution to health
Inclusiveness in the value base for health care resource allocation

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Abstract

This paper provides an overview of the contributions of community medicine in priority setting and resource allocation in health care. It focuses on the role of community in health care and highlights how moral arguments for community involvement can be translated into specific processes needed to implement this approach in practice. Different examples of where community medicine sought to define and measure the outcomes of health services are discussed. The paper also highlights challenges around the weighing up of claims and the elicitation of community preferences, many of which were acknowledged and debated by Mooney himself.

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limited uptake of economic evidence for priority setting in health care. He has lamented (along with other economists) how little is made of priority setting techniques such as Programme Budgeting and Marginal Analysis and QALY league tables which were originally welcomed as a more 'rational, scientific and objective' basis for priority setting (Mooney, 1994, p. 49). These 'economic approaches', designed to address allocative efficiency by weighing up costs and benefits on the margin, have proven to be 'problematical across many settings. Mooney regularly cited the work of colleagues in this area. Jan (2003) for example, argued that techniques such as PIMA suffer from a lack of credible commitment ... in many instances there is no reason why public sector managers and decision makers have an interest in organisational efficiency (p. 20). In a similar vein, Mitton and Donatowski (2003) argued that approaches like PIMA have not been properly applied with an understanding of the decision-making context of health organisations (p. 344). Such problems led Mooney to ask:

'Could it be that health economists are missing the target when approaching the priority setting task? ... There is a worry that while health economists are entrusting the virtues of QALYs, CUA and marginal analysis, the policy makers are not listening because they do not see the world of priority setting in the way that health economists think they do or that health economists think they "should" see it ... there may be a need to reconsider our own [health economists] disciplinary stance' (Mooney, 1998, p. 1172).

The answer, for Mooney, lay in community values. According to him, communities have an interest in organisational efficiency and the long term sustainability of their health services. Why not then ask them to set the principles on which the organisation, in this case the health service, is to be based A key feature of this proposition was to separate out the task of setting principles or values to guide how resources are allocated to different groups in society (to be done by the community) from the role of decision making based on these community values (to be carried out by health service decision makers). I will come back to community values and communitarianism in the next section of the paper. But for now, the key point is that for Mooney, this shift in property rights over resource allocation decision making towards the community provided 'a clear basis for increasing the probability that recommendations from PIMA exercises and the like would be implemented' (Mooney, 2003, p. 253). The examples i present later suggest that there is merit in this proposition but like any priority setting approach, there are challenges to be weighed up.

Finally, Mooney's criticisms around the relevance of priority setting techniques such as PIMA or QALY league tables (and his shift towards communitarian claims) should never be misconstrued as an abandonment of the core economic principles underpinning such techniques. This would be throwing the baby out with the bath water, not to mention all the years he spent educating policy makers and health professionals across the globe about the importance of resource scarcity, opportunity costs and marginal analysis. Rather, Mooney argued that at a policy level, the principles underlying these techniques needed to be better understood and applied more widely than is currently the case (Mooney, 1994, p. 50). He argued that the process of priority setting in health care needs to be 'put more in context' and a shift to a 'communitarian base' for priority setting can, according to Mooney, help with this.

In this paper I will discuss his contributions to the topic of 'communitarian claims' as an ethical basis for priority setting in health care. I will begin by explaining his motivations for seeking a new paradigm in economics and what he meant by communitarian claims. I will then explore some of the criticisms levelled at this new paradigm and its implications for equity. The paper ends with some practical examples of where Mooney sought to apply communitarian claims to priority setting in health care.

Communitarianism and communitarian claims

Communitarianism is a social philosophy that favours social formulations of the good and is often contrasted with liberalism, which assumes that the good should be determined by each individual (Elston, 1993; Class & Rud, 2012). In the 1980s communitarianism was largely advanced by Charles Taylor, Michael Sandel, and Michael Walzer who together criticized liberalism for its failure to realize that people are socially "embedded" and can have a strong attachment to their societies. For communitarians, the values of community (starting with families, then on to neighborhoods, and extending to clubs, schools, towns, and beyond) are important for balancing societies too often tipped in the direction of selfishness, greed, and power seeking (Class & Rud, 2012). They argue that the only way to understand human behaviour is therefore to picture individuals in this social context where the community itself is valued (Avineri & de-Shalit, 1992). This is in direct contrast to liberalism that is based on an autonomous and self-interested person (Dahrendorf, 2006).

'Communitarian claims' (Mooney, 1998) was built upon Broome's concept of a claim (Broome, 1991, p. 137) that entailed 'a duty owed to the candidate herself that she should have a good(s). The communitarian version of claims, put forward by Mooney, extended Broome's definition by recognising that a 'duty is owed by the community of which the candidate is a member and secondly that the carrying out of this duty is not just instrumental but a good in itself (Mooney, 1994, p. 1176). Claims are essentially 'reasons', supported by a notion of duty, why one group should be allocated more resources than another (Mooney, Jan, & Weismann, 2002).

Under this approach, citizens take the lead in determining the principles or values that are to guide priority setting (this is what Mooney called 'setting the stage') but others (primarily policy makers) are the ones to plot the process of health care planning (Mooney, 1998, p. 1173). According to Mooney 'it is only when the rules are broken or the principles not being adhered to will the citizens become directly involved again [in priority setting] (Mooney, 1998, p. 1174). Moreover, communitarian claims are not absolute with respect to their being met. When not all can be met, society needs to allocate resources to those individuals with relatively stronger claims' (Clearly, Mooney, & McIntyre, 2010, p. 465). In this way, scarcity of resources and the need to consider the opportunity cost of treating one claim over another remain pivotal to the approach.

Applying this paradigm in practice involves the elicitation of community preferences. Mooney advocated bringing a group together who are representative of a wider community and providing them with information about the health of the community, about available resources and how these resources are currently used. This group would then be asked to reflect and discuss together what values they would want decision makers to adopt when making resource allocation decisions. In essence, the group are asked to debate amongst themselves what to them constitute the bases for claims (e.g. age, gender, capacity to benefit, socioeconomic status, geographic location, etc.). They would be given information about these groups (e.g. people living in remote areas, the poor, etc.) in their community and then asked to determine the relative weights to be attached to the claims of these different groups. Under the communitarian claims approach, citizens are not being asked to make decisions per se, rather to determine the bases for claims and their relative importance (or weighting) which would
in turn be used by bureaucrats and health care planners to guide their resource allocation decisions (Mooney, 2005).

A new paradigm for allocating health care resources: questions and challenges

So what is new in all this? Where do communitarian claims depart from other economic approaches to priority setting like PBMA and QALY league tables that are based on a welfarist view of the world? Mooney had a lot to say on this topic but two areas where he was most vocal concern the role of citizens and the processes for collective decision making.

Citizenship

Under Wellmarism, individual welfare is the basis for judging the state of society and the performance of social institutions. Social welfare is conceived as an aggregation of individual utility functions resulting in what Mooney referred to as an 'individualistically based social welfare function' (Mooney, 1998, p. 1776). As already noted, this is grounded in a notion of methodological individualism which assumes that all social entities can be explained by looking at the behaviour of individuals within that entity (Goldfield and Gilbert 1995). In contrast, communitarian claims are derived from some concept of a 'citizen' who is part of a wider community that broadens their motives for social choice beyond the simple maximisation of their own wellbeing to allow for other possible motives for choice such as obligations to others (Sen, 1985). In line with Sen (1982), Mooney argued that involving citizens in the process of setting the procedural rules for priority setting in health care can bestow a benefit in itself (Mooney, 2001). The topic of procedural justice is explored further in this series by Stephen Jan.

Underlying communitarian claims is the expectation that communities will be compassionate and a pervasive 'community conscience' will prevail (Mooney & Jan, 1997). On this topic, Mooney likened to cite the work of Nussbaum (2001) who asked: 'How can the public culture of a liberal democracy cultivate appropriate compassion and, how far should it rely on this admittedly fallible and imperfect motive?' Communitarians have been criticised for being unnecessarily optimistic on this front and overlook the 'politics of community' which can be both inclusive and exclusive, both hierarchical and egalitarian (Fraser, 1995). Critics provide examples from the past where 'community life' was based on involuntary relationships and that we should be suspicious of calls for 'community' since historically these have been accompanied by oppressive sentiments such as nationalisms, militarisms, racism, and religious and other intolerances (Younkin, 2000). It has also been argued that modern society is too complex, dynamic, and diverse to succumb to the idea of such an all-encompassing caring community (Younkin, 2000).

Mooney recognized that compassion cannot always be assumed in public life and public institutions. He again supported Nussbaum in arguing that there is a need for an education in compassion as part of good citizenship, that "every society employs and teaches ideals of citizenship, and of good civic judgement, in many ways" (Nussbaum, p. 426). Mooney was not alone in believing that compassion was something that could be fostered through increased social cohesion, arising from citizens' active participation in community discourse (Dixon et al., 2005). He takes what can only be described as an optimistic view of human behaviour; people are or can learn to be compassionate. The only way of confirming whether this is aspirational or a true reflection of practice is to ask communities themselves and this is something I will come back to alter in the paper.

Lastly, 'community' is a term that can embrace many different groupings including all types of social groups (schools, organizations, families, neighbourhoods) as well as geographical groups (towns, states, countries, regions). Individuals can also belong to more than one community and many different social groupings can exist in one specific locality (Hoggett, 1997). Dominant individuals or groups of individuals may exist within some or all of these groupings. Each of these factors can influence the validity of an identifiable and functioning 'community'. Again, the importance of these factors must be tested on a case by case to gain a much clearer picture of the true 'community reality' when using community values in priority setting and resource allocation in health care. (For a comprehensive critique of communitarianism see for example Fraser, 1995).

Processes for collective decision making

To make social choices, economists have typically employed collective choice 'rules' (Sen, 1982). These rules designed to suit the mathematical construct of social welfare functions are tested under varying sets of conditions, most notably the condition of Pareto Optimality that involves the greatest utility or happiness for the greatest number of people (Sen, 1970). Rules of collective choice can take different forms ranging from the simpler ordinal methods like majority decision and rank ordering through to those that give greater emphasis to a societal perspective and the interconnectedness between individuals. An example of the latter is the 'normative indicator' method that involves making judgements or 'interpersonal weightings' often based on criteria such as income level or socioeconomic status (Sen, 1982). Using this approach citizens have been asked to assume the role of a health care planner and allocate an additional but fixed amount of health care resources across pre-defined health services or population groups (see for example Wiseman, 2004; Wiseman, Mooney, Berry, & Teng, 2001). Participants are also given varying levels of information to do this. These weightings are then summed to derive a social or aggregate weighting. Approaches like this attempt to move from purely individual to social preferences - taking account of the welfare gains and losses to different groups - as a basis for setting health care priorities.

While Mooney supported approaches to priority setting that did not rely exclusively on an individualistic model of behaviour, he was sceptical of using information that could only be mechanically collected by the summation of community votes (Mooney & Blackwell, 2004). This brought him to explore more 'dialogic' methods of collective decision-making like citizen juries that rely on a process of community discourse. In 2004, along with colleagues in Western Australia, he embarked on an ambitious programme of research, using citizen juries to involve the public in decisions about health care provision (Mooney & Blackwell, 2004). These studies, based on random samples of citizens, asked jurors to deliberate and make decisions for the whole community, not just themselves as individuals. They were given time to discuss, ask questions and make decisions. The jurors identified and debated the principles to guide priority setting such as equity (defined as equal access for equal need) and applied this principle to three areas of inequity in Western Australian health services: Aboriginal versus non-Aboriginal healthcare; rural and remote healthcare versus urban healthcare and aged versus other healthcare. Jurors were then given a nominal sum of money and, on the basis of their deliberations and listening to and questioning of the experts, were asked to allocate this money across the three identified areas. According to Mooney et al., citizens 'were able to do this, giving greatest priority to reducing inequities in Aboriginal health' (Mooney & Blackwell, 2004, p. 76).
Citizen juries are one of a number of approaches to the deliberation, elicitation and aggregation of community preferences. For a comprehensive review of methods of eliciting community preferences see for example Ryan et al. (2001). To date, they have not been widely used in the health sector and it is difficult to draw firm conclusions about how they match up to other approaches in terms of acceptability, cost and effectiveness. Moreover, little attention has been paid to the potential inconsistencies that can be thrown up by dialogic approaches like citizen juries. For example: can it be assumed that 'communal discourse' will eventually reveal a consensus outcome? If not, then some 'rule' may still be needed to resolve the differences and to make a collective choice. More information is also needed on their acceptability especially from the perspective of managers and policy makers, some of whom are likely to see this as a dangerous shift in property rights over decision making to lay community members. Finally, in most cases citizens are being asked to allocate hypothetical sums of money across different types of health services or different population groups. Little is known about how participants view these hypothetical exercises and how outcomes and processes might vary compared to 'real' priority setting decisions.

Coming back to the question raised at the start of this section: where does the communitarian claims approach depart from current methods for priority setting such as QALY league tables and PBMA? Unlike QALY league tables, communitarian claims allow for the possibility that processes are valued not just outcomes. Moreover all the values adopted in the way that resources are allocated between different groups are those of the overall community not just the individual. The distinction between PBMA and communitarian claims is less clear-cut. One of the main limitations of PBMA according to those who advocate its limited utility is that the values derived from such exercises have been implemented. As noted earlier in this paper, Mooney largely attributed this to a lack of 'credible commitment' by managers causing such exercises to break down. This situation results from the conflict between individual objectives of each manager to maximise his/her budget and the perception that such actions will fail to achieve institutional objectives by providing in good faith, information that might then be used to cut his/her budget (Jan, 2003, p. 272). According to Mooney, communitarian claims offers an answer to this problem by altering the distribution of property rights in favour communities who are likely to be around longer than bureaucrats and politicians (Mooney, 1998, p. 248) and who 'value their own social institutions' (Mooney, 1998, p. 248). In this sense, communitarian claims, represents an extension rather than an alternative to PBMA. Costs and benefits are still being weighed up at the margin but these decisions are guided by goals or principles established by the community for the community.

**Equity and communitarian claims**

Communitarian claims brings together the notions of 'community' and 'equity', or more precisely vertical equity (i.e. the unequal but equitable treatment of unequals). It has been noted by how under communitarianism people are defined not just as individuals but as social beings. They value the community and its institutions and value being part of that community and participating in the community (Mckinstry & Mooney, 2007; Black & Mooney, 2002). It is the community as a whole that determines what constitutes a claim and what the 'strengths' or 'weights' are of those claims. It is these 'weights' that according to Mooney are 'born of vertical equity' (Mckinstry & Mooney, 2007, p. 64). This is the case insofar as the benefits to some disadvantaged groups within the community might be weighted more highly than others even if the benefits are nominally equal. The size of these weightings will be a function of how compassionate the community feels towards the disadvantaged' (Mckinstry & Mooney, 2007, p. 64). Weighted claims would constitute the basis for allocating scarce health care resources across different groups in a society and more importantly how equitably they are allocated.

Communitarianism views the allocation problem as a whole acknowledging disadvantaged people and facilitating their access to better health and health care. He saw this again in direct contrast to current thinking in health economics where 'the social good of equity struggles to be based on anything other than individuals having some sort of concern for other individuals'. In health economics this has been dubbed the 'caring externality' that occurs when individuals receive benefit from knowing that other people are receiving medical treatment. For instance, it may be useful for the purposes of resource allocation to define the population in terms of age groups as suggested by Williams (1997). Alternatively, social class, existing health status, capacity to benefit, age or indeed smoking status may be seen as forming bases for differential claims.

The second task of operationalising a 'claims' approach was to determine the relative importance in social access to health care could not be reduced to a form of market failure nor simply measured in terms of a reduction in individual utility. Equitable health care policy needed to encompass the social good that comes from 'valuing the community as a community and wanting it to be a decent community' (Mooney, Tinrghog & Kalkan, 2012, p. 123).

Mooney does not deny that the conceptualising of vertical equity in health care was difficult. He argued that to operationalise this approach, it was first necessary to establish what basis claims are to be established. This involved the task of partitioning the population into groups, which are meaningful in relation to the objective of allocating resources fairly. For instance, it may be useful for the purposes of resource allocation to define the population in terms of age groups as suggested by Williams (1997). Alternatively, social class, existing health status, capacity to benefit, age or indeed smoking status may be seen as forming bases for differential claims.

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Over the past decade Mooney was involved in a number of studies that sought to explore how best to unpack the constituents of claims and their relative importance in social access to health care. In 2011, along with colleagues from South Africa, he conducted an investigation of how the communitarian claims framework could be applied to resource allocation decision making in the area of treatment for HIV/AIDS in that country (Chiray, 2010). They identified different ways of structuring claims and provided examples of what claims might comprise and how the use of these might in turn influence policy on HIV/AIDS. It was however in the context of Australian indigenous health that Mooney was perhaps most active in advocating communitarian claims (Mooney et al. 2002). In the late 1990s, with the support of indigenous communities in Australia, he explored how the broad framework of PBMA could be implemented using the combined methods of structured interviews and group discussions (Wiseman & Nona, 1998; Wiseman, Daley, Mooney, Williams, & Williams, 1999). This work sought to extend the elicitation of preferences into areas where not only outcomes but also processes are valued for the equitable allocation of health care resources. Mooney's later work with citizen juries, discussed earlier in this paper, was a continuation of this work on equitable processes for eliciting community preferences. Together, these studies identified a wide range of bases for claims including (although not exclusively): the need for health care (typically defined in terms of ill-health); gender, age, income and geographic location of claimants; capacity to benefit; the impact of provision of care on individuals, households, communities and the overall economy; and meeting the needs of the most disadvantaged groups.

Much of the research on communitarian claims as a basis for resource allocation in health care has been about the development

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of frameworks, methods (such as citizen juries) and guidance documents for policy-makers. The metrics to support (or not) their implementation is lacking. The studies mentioned above are mostly limited to small pilot exercises involving (although not exclusive to) non-representative samples of the population. Evaluating the communitarian claims approach, particularly in terms of its sustainability beyond the life of the initial project, is a critical next step. By nature, one would think that involving the community and building social values into the priority setting process would bring the 'credible commitment' (Jan, 2003), or what policy-makers often call 'buy-in', to sustain the process. However this needs to be tested within the day to day operation of health services. Most conventional forms of economic evaluation used in the process of priority setting also overlook the importance of sustainability, there is a research gap to be filled here.

Conclusion

Mooney’s mantra was to return health services and health policy more generally to the communities they serve, both nationally and globally. While he would probably be the first to acknowledge that the weighing up of claims can be highly contentious and that eliciting community preferences faces many challenges, he would be proud of the ground he made in getting policy makers and many academics to consider more carefully the value bases or principles on which health systems and services operate. In theory and in practice, Mooney laid the foundations for communitarian claims as an alternative health economics paradigm.

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References


Proceduralism and its role in economic evaluation and priority setting in health

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ABSTRACT
This paper provides a critical overview of Gavin Mooney's proceduralist approach to economic evaluation and priority setting in health. Proceduralism is the notion that the social value attached to alternative courses of action should be determined not only by outcomes, but also processes. Mooney's brand of proceduralism was unique and couched within a broader critique of "neo-liberal" economics. It operated at a number of levels. At the micro level of the individual program, he pioneered the notion that "process utility" could be valued and measured within economic evaluation. At a macro level, he developed a framework in which the social objective of equity was defined by procedural justice in which community values were used as the basis for judging how resources should be allocated across the health system. Finally, he applied the notion of procedural justice to further our understanding of the political economy of resource allocation: highlighting how fairness in decision making processes can overcome the sometimes intractable zero-sum resource allocation problem. In summary, his contributions to this field have set the stage for innovative programs of research to help in developing health policies and programs that are both in alignment with community values and implementable.

Introduction

Through his prolific and original contributions across numerous topics, Gavin Mooney is often considered one of the most innovative and influential health economists of his generation. This paper draws mainly on the legacy of some of his later work, in which he reflected more critically on health economics as a discipline and the direction taken in much of its analysis. The focus of Mooney's concerns were the values and power relationships that influence decision making in the health sector and often go unquestioned in conventional health economics research, which Mooney tended to label as "neo-liberal" (Mooney, 2009). His criticisms, which centre on the normative foundations of health economic analyses, can be broadly categorised into four related points: 1) economic evaluation and the implicit social welfare judgements that it purports to inform fail to reflect community values; 2) that outcomes other than health (and its proxies) are not valued in economic evaluation; 3) that process also get overlooked and; 4) that priority setting initiatives, which bridge economic evaluation evidence to policy, tend to frame decision making as a zero-sum game and as a consequence, encounter problems of implementation. Mooney and colleagues provide means of getting around this impasse through institutional design in which procedural issues play an important role.

The focus of this paper is on Sections "Process Matters" and "The Overlooked Political Economy of Decision Making" - which are about process and in particular, what we can label as Mooney's 'proceduralism' (which contrasts with the inherent 'consequentialism' in conventional health economics). This proceduralism is part of a wider, coherent critique of health economics and to fully appreciate it, the issues raised in Sections "The Community Voice is Often Ignored" and "There is More to Health Care than Health" will need to be briefly covered. Each of the four points helps build the rationale for an alternative normative approach put forward by Mooney in which the core health economics problem of allocating scarce health resources can be tackled.

The community voice is often ignored

This criticism is directed at the way in which health economics conducts normative analyses and in the purported mismatch between the objectives of economic evaluation and what it is that
communities want from their health systems. This has been affirmed in studies of community values where cost-effectiveness and efficiency as preferred goals for the health system have been trumped by principles of equity (Mooney & Blackwell, 2004; Mooney, Jan, & Wiseman, 1995). In eliciting these preferences over the allocation of resources, Mooney argued that the distinction between an individualistic rather than a communitarian perspective is important (Mooney, 2005, 2006; Mooney, Jan, & Wiseman, 2002). He argued that communitarian preferences are in principle different from individual preferences because the former require respondents to throw off the straightjacket of self-interest and make judgements about health policy and resource allocation as a citizen. In Mooney’s worldview, the voice of the community is not defined by an agglomeration of individual interests but a broader set of values in which individuals’ regard for one another is factored into priority setting decisions. It is through taking on the role of citizen that concerns for those with least voice and power such as indigenous Australians are heard and their claims on resources acknowledged. He argued reasonably that framing choices around the conventional imperative of individualistic preferences gave little space for these values to be articulated.

However, a potential weakness in Mooney’s position is that it assumes that individuals can have these separate identities as citizen and as individual, and do employ them when asked, putting aside personal interests and possible incentives for gaming. Recognising this, some of the methodological responses to these challenges that Mooney employed in his own empirical applications have included the framing of these questions from the perspective of a ‘decision maker’ and the use of deliberative processes such as citizens’ juries, which require individuals to put forward and potentially substantiate their views among peers.

It is important to recognise that Mooney made no claim that individuals’ selfish preferences should not matter in determining priorities. His position was that the valuation of individual programs are best carried out by end-users and that individual utility in this context has an important role in program evaluation and in informing priorities. However, his argument was that this was not enough and that individual preferences alone can create inequities. His approach was to overlay citizen preferences onto this process, in a sense establishing a visible hand to moderate the inequities that can be created by the interplay of individual preferences.

A deeper concern is the question of why it is that a communitarian as opposed to an individualistic approach should be used for decision making. This is the type of question that tends to create in economists some level of discomfort as it is a problem, deemed by many, to fall within the realm of ethics rather than economics. Mooney understood that this is a false dichotomy; practicing economists routinely invoke values based on the ethics of individualism which by default are built into conventional economic approaches. As such he contended that an important part of the economist’s repertoire has to be a willingness to engage in arguments of ethics, and an ability to identify and defend whichever value system they are operating within (Mooney, 2008). In response, Mooney developed and articulated his own ethical framework where communitarian as opposed to individual preferences were established as the bases on which to define and value social welfare (Mooney, 2005). See also Wiseman’s companion paper in this series.

There is more to health care than health

Economic evaluation in health and health care tends to be carried out in a manner in which the outcomes are posed exclusively in terms of health, or its proxies (usually intermediate measures whose justification is anchored on some statistical or conceptual association with health status). This is reflected in the dominance of what can be called the QALYs (Quality Adjusted Life Years) paradigm in which the benefit from health programs is judged in economic evaluation solely in terms of health outcomes (usually QALYs). Mooney argued, and gathered supporting evidence including his own studies on this question, that patients often value other outcomes such as patient autonomy, information: factors that may be of value independently of a QALY (Mooney, 1994a; Mooney & Longe, 1997). Furthermore, he argued that each person will value health as an argument within their utility function differently — for some, health may be a dominant consideration in relation to other things of value in their life. For others, this may be less so. The point is that the way in which health economists conduct economic evaluation presents does not allow preferences over this trade-off to be considered. In summary, his position with respect to this point was that: i) health sector programs may generate utility through their impact upon non-health outcomes and these benefits are relevant in evaluation and; ii) individuals will vary in the value they place on a QALY relative to these other non-health outcomes (Mooney, 1994a) and that individuals’ preferences can be used to determine the weighting assigned to QALYs in each individual.

This position was put forward as a criticism not only of conventional health economics but of much of public health practice which tends to assume, in both the design of programs and in their evaluation, health to be the dominant, if not only, objective (Chapman, 2000). By arguing that there is a potential trade-off to be made between health and other sources of utility and that individuals’ preferences should be the arbiter of this trade-off (Mooney, 2006, 2010b) Mooney interestingly stands more on the side of welfare economics, as it is generally conceived outside of health economics. Ironically, on this issue, he adopted a position that one might argue is more ‘neoliberal’ than that of his opponents.

Process matters

One area of conventional health economics and economic theory that Mooney was relentless in his criticism was its basis in consequentialism (Mooney, 2005; Mooney & Jan, 1997). Consequentialism is the notion that actions ought to be judged exclusively by their outcomes and that the processes that help us get to these outcomes are valued solely for their instrumental role; in other words, it promotes the idea that the ends justify the means. Such consequentialism has long held sway as the standard model underpinning much of the economic evaluation carried out in health, through cost-utility or cost-effectiveness analyses. As shorthand I will label this standard model, the QALY paradigm. It differs from the conventional welfarist approach because its objective function is based solely on health or QALYs rather than the broader notion of utility. Mooney in critiquing the QALY paradigm, highlighted the importance of process, both in terms of the value attached to individual health programs (process utility) and as a dimension of equity (procedural justice).

Process as a source of individual utility

At a micro-level, the processes involved in the delivery of programs can, in themselves, be of value to patients and users. This may seem self-evident, but there is nothing in the QALY paradigm that necessarily enables factors to be admitted into the evaluative space such as having a friendly and empathetic nurse, a doctor who takes time to explain diagnoses and the ability to choose between day surgery and an overnight admission for a medical procedure. These are examples of processes of care that can be of direct value.
and in Mooney’s lexicography, ‘process utility’ (Mooney, 1954a, 1954b; Mooney & Lange, 1991). In research conducted in his later years, this idea of process utility was found to also highly resonate in Indigenous health, where there has been a long held view that community ownership of health care programs are integral to their acceptability (Mooney et al., 2002).

Accepting that process utility may exist and be relevant as an argument in the social welfare function means that methods of economic evaluation need to be broadened according to capture these sources of value. One alternative to the largely prevailing QALY’s approach that would potentially allow for the inclusion of process utility (as well as non-health outcomes) into the evaluative space is cost-effectiveness analysis where the measure of benefit potentially captures simply whatever it is that end-users define to be of value. Whilst contingent valuation methods have been used for many years in health, they have not really enjoyed a broad base of acceptance most likely due to equity concerns over willingness to pay valuations, informational limitations encountered by respondents and methodological issues such as framing biases and scale insensitivity. The introduction of discrete choice experiments and conjunct analysis in health holds some promise for widening the scope of economic evaluation to include such multiple attributes within a cost-benefit framework (Jan, Mooney, Ryan, Bruggemann, & Alexander, 2006; Ryan & Farar, 2006).

Another approach to capture process and non-health outcomes is cost-effectiveness analysis in which costs are presented alongside a suite of measures pertaining to the ‘consequences’ of the program in question (Jan, Prony, & Kim, 2008). Evidence of cost-effectiveness provides potentially a rich and comprehensive account of the value generated by a program: which has also been referred to as the ‘basket of goods’ approach (Drummond, Stoddart, & Torrance, 1988). The apparent downside of this approach is that by providing multiple measures, no clear decision rule is available to decision makers in interpreting the evidence. This is probably a major reason why health economists have largely shunned this approach. However it is not clear that decision makers really want to defer to a simple cost-effectiveness calculus in their decision making; accepting by default the various assumptions and shortcuts needed to arrive at a simple incremental cost-effectiveness ratio. As cost-effectiveness analysis requires some element of interpretation and value judgement in weighing up a multi-dimensional set of consequences, it seems more compatible with the notion of decision-makers actually making decisions. In applying this approach, an important safeguard against the risk and perception of data mining is the need for the relevant consequences of a program/intervention to be pre-specified and that this specification is informed by explicit theory (Jan et al., 2008).

Process as a vehicle for attaining equity as a social goal.

In Mooney’s world-view, there was another normative dimension to process. It was that the achievement of equity within a health care setting generally involves not only normative judgements about the distribution of outcomes, but also judgements about the fairness of the processes involved in making these distributions (Mooney & Jan, 1997). In other words he saw procedural justice as an important goal of health systems in achieving equity (which we use to mean the same thing as ‘fairness’ – a term that Mooney was inclined to use in the same way).

So, how does one judge whether a process is fair? Mooney, adopting his communitarian stance, suggested that a community perspective is the only legitimate way of making these judgements. The premise being that in making equity judgements, someone has to decide the relative harms being visited upon different groups and individuals in the community, and in turn establish the concordant claim that that group or individual has over resources to redress such harms. However, “the strength of a claim is not a function of an individual’s ability to manage to feel harmed. Harms and the strength of these harms are for society to judge. Strictly, with respect to claims, the bad feelings arising for the person harmed are only relevant insofar as the society deems them to be relevant”. (Mooney, 2009, p. 155).

Mooney in promoting this view often cited a similar observation made by Sen in his own critique of welfarism. Sen’s argument is that people’s preferences are generally circumscribed by the expectations that they have set. Those who sit at the bottom of the social ladder may have truncated expectations conditioned by a lifetime (and perhaps generations) of limited opportunities and thwarted lifeplans. Put another way, a part of the condition of social disadvantage is a narrowing of horizons in which individuals envisage a better life for themselves, their families and peers. This means that a simple welfarist approach, which operates through a calculus of individuals’ preferences, may be inherently unfair as it has a built-in bias against those in whom there is an ‘inability to desire’ (Sen, 1982).

The implication of this was that community consultation based around citizen preferences was seen to be inimical to the attainment of an equitable health care system. Decisions about how resources should be allocated, and specific questions such as the weight to be attached for instance to socioeconomic disadvantage, Aboriginality, cost, availability of infrastructure and (should) be questions that are addressed by the community. To this end Mooney was the architect of citizens’ juries initiatives in a number of jurisdictions (Mooney & Blackwell, 2004). It is possible however that this solution, in seeking to address a dimension of disadvantage may create another, through the imposition of what might be considered paternalistic preferences on those who are deemed to lack capacity to make their own decisions. Furthermore it remains to be seen whether the possibly utopian premise that communities will privilege the interests of the downtrodden holds up in different settings; and whether in some societies communitarian values lead to decisions that reinforce rather than redress disadvantage, particularly where there is a prevailing level of institutionalised persecution of minorities. Thus far, Mooney’s communitarian approach has had limited testing in resource allocation problems outside those that concern Australian Aboriginal populations.

Aside from Mooney, a number of commentators have invoked the notion of procedural justice as a goal in system level decisions about resource allocation. The most notable of these is Daniels and Sabin, who developed the ‘accounting for reasonableness’ principle, an ethical framework for decision making in relation to the priority setting problem or to use their term, ‘limit setting decisions’ (Daniels & Sabin, 1997). They specify four normative criteria for assessing whether processes are judged to be fair: 1) that the reasons chosen are relevant to the problem at hand; 2) that reasons and rationales are publicly accessible; 3) that there is scope for appeal by parties involved in this process and; 4) there is some form of public enforcement process in place. As a point of contrast with communitarianism, within the ‘accounting for reasonableness’ framework, community consultation is offered little more than a secondary role; it’s job confined to simply adjudicating an appeals process (Sabin & Lue, 2008). As a normative framework for assessing processes for health sector decision making however, it is probably the best known and has been applied extensively (Gibson, Martin, & Singer, 2004; Malin et al., 2011). An alternative proposed by Wailoo and colleagues is based on a seemingly similar set of criteria ‘voice’, ‘consistency’, ‘absence of vested interests’, ‘transparency’, ‘reversibility’ and ‘accuracy of information’ (Tschuya, Miguel, Edlin, Wailoo, & Dolan, 2003; Wailoo & Anand, 2005).
The feature of these two approaches is that the criteria that underpin them provide specific guidance as to the assessment of procedural justice and in this sense, are prescriptive. In practice, the criteria are broad enough to accommodate a wide range of interpretations, depending on context, in their application, however, they may involve potentially conflicting aims e.g. the idea of 'consistency' in decision making can conceivably be at odds with the notion of 'reversibility'. Establishing the parameters for each definition, their potential trade-offs and the problems of who becomes the arbiter as to whether these goals are achieved, seem to be unanswered questions.

Saiwak and Lie highlight some of these complexities in translating high-level principles to operationalizable criteria and suggest that the condition for procedural justice be set simply in terms of "consultation" and deliberation "over substantive principles" (Saiwak & Lie, 2008). In practice this implies an open agenda in which it is a community of stakeholders who determine the principles that govern priority setting decisions rather than having these pre-specified, as in earlier accounts above. By allowing consultation to determine from first principles a set of higher order and 'de-personalised' rules for resource allocation, the framework advocated by Saiwak and Kie resembles in practice Mooney's communitarian framework where the focus is upon eliciting citizens' as opposed to individualistic preferences.

The overlooked political economy of decision making

Another dimension to Mooney's proceduralism is the role of preferences with respect to procedures in policy implementation. In particular, he saw the attainment of procedural justice — a perception that the processes by which decisions are made, as opposed to simply its outcomes — as important instrumentally in ensuring the implementation of economic priority setting initiatives in the health sector. The priority setting problem, as defined by economics, starts with a budget constraint and from there, involves a choice between an exhaustive array of alternatives for spending. The focus of this section is to examine the work Mooney and colleagues undertook in the wake of some of his priority setting exercises to determine the reasons why in practice they may or may not have been successful in implementation (Jan, 2000, 2003; Mooney, 2009).

Health sector decision making takes place within a political economy characterised by the interactions of multiple and competing interests. Within this milieu are invariably asymmetrical power relations which create the tendency in decision making, particularly in relation to decisions over the allocation of scarce resources, to favour the powerful. Existing models of priority setting such as program budgeting and marginal analysis (PMBMA), that are about providing guidance for 'rational' and evidence-based decision making, are generally presented in a manner biased towards these power relations. Implementation is assumed to be a process of seamlessly allocating and re-allocating resources to where, on the basis of evidence, they achieve their greatest marginal benefit. At the centre of the implementation problem is the premise that managers as part of these exercises, are expected to provide evidence in good faith which in turn can be used to potentially cut their budgets (Jan, 2000).

How then do we address this incentive compatibility problem? One way would be to turn our attention to the processes involved in making these decisions. A focus exclusively on outcomes (or consequences), in which there are invariably winners and losers, will inexorably lead to a zero-sum conflict over resources. As the stakeholders in these exercises are usually senior managers or clinicians with the power to exert a veto, the prospects for implementation in this type of institutional setting tend to be low.

The key in this situation is to achieve procedural justice by ensuring that the rules of the game are acceptable to players prior to outcomes being known (Jan, Dormers, & Mooney, 2003). These principles would need to be pitched at a high level to de-personalise the process. A communitarian approach, involving citizen rather than individual preferences, at least in principle, achieves this by removing from deliberation arguments of self-interest about individual allocations. To be sure, getting the institutional design right to facilitate implementation in this manner may require other measures that have been shown to enable co-operation such as ensuring that the process is understood by all to be repeatedly over the long-term (as opposed being to the one-shot game); information that is shared amongst players and that the rules are restricted to small numbers of stakeholders (Jan, 2000, 2003).

Some of these measures were crucial to a study of implementation based on proposed changes to a funding formula across Divisions of General Practice in Australia (Jan et al., 2003). The proposed reforms were about adjusting the relative shares of funding from a fixed global budget across Divisions through an alternation in the funding formula. The key to achieving implementation was deemed to be consultation through a series of meetings and the development of a consensus document produced iteratively through input from all stakeholders. This process was effective in promoting amongst relevant players a sense of procedural justice and in facilitating broad acceptance of its eventual outcomes. There were also other design features that enabled those involved to overcome the perception that the process was simply about robbing Peter to pay Paul including: the pitching of deliberations around de-personalised principles in which participants were required to step into the shoes of the decision-maker; and creating an understanding amongst players that the general principles derived from the exercise would pertain to an ongoing cycle of priority setting rather than as a one-off.

The implications of this is that the formulation of rules by which scarce resources, in whichever context the priority setting problem is to be applied, is crucial not only because of the rules potentially lead us to socially desirable outcomes but because the processes in which we employ them influence how well they are to be implemented. A number of measures can alter the way in which the ostensibly zero-sum problem that characterises many resource allocation decisions can be re-framed to one that is much more tractable; the key being the attainment of procedural justice through ongoing consultation.

Conclusion

In conclusion, this paper provides an account of Mooney's legacy in the seemingly evolving task of formulating a normative standard for health economic evaluation and priority setting. One of the features in the development of health economics as a discipline has been a willingness of its practitioners over the years to embrace innovation and adopt normative criteria that are at variance with those generally espoused in conventional paternalism. This is evident most notably in the emergence of QALYs as the dominant currency of health economic evaluation. Mooney's role, as documented here, has been to issue further challenges that can be encapsulated in the simple question posed in the title of a 2004 paper: 'what else do we want from our health services?' (Mooney, 1994:6). Proceduralism, and in particular Mooney's take on it, provides health economists the intellectual spark to go on and better answer this question. It gives us reasons to investigate values that individuals assign to the processes of receiving health care as well as to design, at a higher level, consultative processes for determining the allocation of society's health sector resources. Such research will ultimately enable the generation of health economics.
evidence that aligns more closely with the values of the community and encourage the formulation of policy that is both fair and readily implementable.

References


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Celebrating the work of Gavin Mooney: Inclusiveness and involvement in global and public health issues

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Abstract

This paper considers Gavin Mooney’s contributions to the research literature on inclusiveness in global and public health issues. Much of his contribution in this area stems from engaging with indigenous people, which cemented his conviction that it is important to recognize the heterogeneity of groups in society, especially in relation to cultural differences. He believed that in order to develop appropriate, equitable and efficient health and related policies, the preferences of citizens should be elicited. While this could feed into very specific policy decisions, such as how to allocate available resources within a particular community, more generally, community preferences should determine the core values that underpin a health system. He proposed that these values be documented in a ‘constitution’ and serve as the basis on which policy-makers and health managers make decisions. Preference elicitation has value in itself, as procedural justice allows for self-determination and contributes to empowerment. Further, engagement by citizens in deliberative processes can overcome polarisation. Health systems themselves, if developed as social institutions, can influence the nature of society and contribute to greater equity.

Mooney raised similar concerns about policies arising from mono-cultural global perspectives and argued that, whether at the national or global level, values for health systems should be based on community preferences. He particularly highlighted the unequal distribution of benefits of neoliberal globalisation as the cause of growing health and wealth inequalities globally.

There is resonance between Mooney’s views on these issues and some of the contributions to the post-2015 development agenda debates. While it is unlikely that we have reached a point where the strait-jacket of neo-liberal governments on key global institutions will be broken, the current debates nevertheless present an important window of opportunity to struggle for shifts in the global political economy. Current debates about universal coverage also provide a critical opportunity to move towards health systems that are built on values determined by citizens and are social institutions that build solidarity, redress inequalities and unite fractured societies.

1. Introduction

Mooney’s passionate concern for equity and social justice stems from his roots in Glasgow, Scotland. His experience of living and working in several different countries, as well as engaging with the hundreds of students from around the globe who signed up for his distance-learning courses in health economics. His years in Denmark exposed him to the social solidarity so evident “... in Scandinavian society ... [which has] a stronger preference for equity and in turn for more equity-oriented health care systems” (Mooney and Houston, 2008: 1164). When he moved to Australia, he was immediately struck by the massive health and socio-economic inequalities between Aboriginal and Torres Strait Islanders and other Australians. This led him to engage extensively with indigenous people and he was deeply affected by their culture and by the stark differences between Aboriginal culture and the prevailing neo-liberal worldview of many governments, Australia being no exception. It was these experiences that led to his enduring opposition to mono-culturalism, both in national and global contexts, to his abhorrence of the individualism propagated by neo-liberals1 and his support for a communitarian approach and for inclusiveness in public health processes.

This paper begins by exploring Mooney’s contributions in relation to social determinants of health in indigenous populations. His experience of working with indigenous communities furthered his
commitment to building health systems on the basis of the values of communities and citizens, so that they are truly social institutions, which can in turn contribute to building more compassionate individuals and societies. After exploring these issues, the review turns to issues of global health and Mooney's views on the dominant forces influencing health inequalities across countries particularly the role of the Bretton Woods institutions. The paper ends with a few personal reflections on the relevance of his work to some current global health discussions.

2. Social determinants of health in indigenous populations

The social determinants of health are possibly nowhere as evident as in relation to Indigenous populations. The Commission on Social Determinants of Health (2007) highlighted that Indigenous people around the world have life expectancies that are lower than the national average in their country. In the Australian context, Mooney et al. (2002: 1658) noted that, "... Aboriginal and Torres Strait Islander people have an average life expectancy of 15-20 years less than that of Australians in general and infant mortality rates around 3-4 times greater than the general population. In some communities, diabetes rates are 15-20% in comparison to 2-3% in the general Australian population. Perhaps, most striking is the evidence that the differences in health status between Indigenous and non-Indigenous populations are greater in Australia than in the US, Canada or New Zealand."

These health inequalities are mirrored by socio-economic differentials between Indigenous and non-Indigenous Australians (and similarly in other countries), which are underpinned by power differentials and differences in culture. Mooney particularly sought to illustrate the adverse health implications of the imposition of policies (whether they are policies addressing social determinants of health or related to the health system) that are based on dominant (neo-liberal) ideological perspectives and that ignore the cultural values of Indigenous communities. This is well illustrated in an analysis of the relationship between employment and the health of Indigenous Australians, where Walter and Mooney (2007: 154) highlighted that the problem was not merely "... continuing high unemployment or 'worklessness' of Indigenous Australians ... [but also] the neo-classical (essentially market) concept of employment which is both unhelpful in this context and alien to Indigenous culture." They critiqued the dominant view that "... the solution was to provide greater access to mainstream employment as the principal vehicle for Indigenous Australians to achieve higher incomes and hence better health, and called for "recognising that different cultures may have different constructs of employment and work" (Walter and Mooney, 2007: 155).

They put forward an alternative conceptualisation of employment, that is more appropriate to Indigenous culture, and explored its relevance to social determinants of health: "Workfulness is proposed as a term to cover not just market employment, but also the carrying out of tasks that are seen as positive for community and/or cultural development. It can thus provide a sense of self-respect and self-esteem similar to that often attributed to market employment in the social determinants of health literature" (Walter and Mooney, 2007: 157). It was on this basis that they criticised proposed changes to an Australian government employment program (Community Development Employment Projects – CDEP), which would focus on assistance for seeking market employment and place pressure on Indigenous people to move to large urban areas with associated "problems with respect to cultural life [particularly due to removing Indigenous people from their country] given the importance of land in Indigenous culture, stigma and explicit racism", with potentially damaging health effects (Walter and Mooney, 2007: 158). They argued that the initial CDEP was structured more appropriately, as it paid "individuals' unemployment benefits to their Indigenous communities, who may then 'employ' these same individuals on various tasks ... [which] may be 'jobs' in the conventional market sense, but may also be contributions to 'community development'" (Walter and Mooney, 2007: 157).

This analysis highlights a point that Mooney made repeatedly over the last two decades: that "problems occur largely when needs [and interventions] are defined by third parties without reference to the heterogeneity of the individuals and groups concerned" and that inherent in this "... is the implication that there is a commonality or homogeneity present: in a society of that differences, which do exist, can be ignored" (Mooney et al, 2002: 1661). Recognising this heterogeneity was instrumental in Mooney arguing for the pursuit of inclusive health systems, where the voices of diverse communities were taken into account.

3. Inclusive national health systems

3.1 Eliciting community preferences and developing a constitution

One of Mooney's most important contributions in the area of public health was to advocate for community values and preferences to guide health service policies and planning (and indeed other policies that impact on the social determinants of health): "... where is the concern to establish what working class people, indeed people more generally, want from public health? The lack of consultation is astonishingly elitist. We need to get out there, asking instead of assuming.... Eliciting community values and letting these drive the public health enterprise is the way forward" (Mooney, 2000).

He devoted considerable effort to demonstrating how community and public preferences and values could be elicited in practise, particularly through his work on citizens' juries (Mooney, 2002a; Mooney and Blackwell, 2004). His first foray into this area of research was to elicit preferences to inform resource allocation decision-making around Indigenous populations (Mooney et al., 2002). He highlighted that the value of such endeavours lay not only in recognising that "... community valuation of the benefit of various programs [is important] given that the output of such programs is likely to be viewed differently by different populations", but also that procedural justice had instrumental value in itself. The "... emphasis on procedural justice rather than distributive justice is that it allows for the promotion of autonomy and self-determination in the decision-making process. The concept of self-determination expresses the right of Aboriginal communities to improve the quality of their life through a process of empowerment" (Mooney et al., 2002: 1962). Autonomy in decision-making in turn has important implications for social determinants: "A community which has autonomy and self-respect is more likely to be a healthy one" (Collard et al., 2003: 503).

Mooney recognised that it is not feasible to ensure community participation in each and every health sector decision. Instead, he was advocating for processes of community deliberation to elicit preferences on what the core values or principles of the health system should be, which would take the form of a 'constitution' that would then serve to guide decision-making by policy-makers and public officials (Mooney, 2012a). He explained that: "We need to devise and adopt a set of principles for social choice – a 'constitution' – and that this required 'clarity on the values that do and should drive the health care system. This set of values has to come from the community.' Hence, one is "using the community voice to establish the values that should underpin it and leave the 'experts' to operationalise the constitution." (Mooney, 2009: 172-173)."
Atohazua and Mooney (2011: 195) noted that: "Some may wonder if it is possible to elicit community preferences and if so how consensual they might be. The practicalities of reaching a community consensus seem less than some philosophers may initially fear." Mooney's experience of citizens' juries was that while different groups may have different preferences in relation to specific health programs, at the level of fundamental values or principles to guide health systems' design, policies, planning and delivery, citizens engaging in deliberative processes were able to reach a considerable degree of consensus. Very importantly, this approach is valuable in providing "... a way of getting beyond the polarization that can occur in any society, where claims are based on market power (primarily income and wealth)" (Mooney, 2009: 177).

3.2. Health systems as social institutions

Part of the outcomes that Mooney envisaged would arise from building health systems on the basis of community values was for the health system to be a truly social institution and not simply a means of providing health services. He argued that health systems are "social institutions, a part of the social fabric and with the capacity to be major players in influencing the nature of society. ... the health care system thus has a value of its own independent of or at least additional to what it produces by way of outputs, such as improved health to individuals. This value takes the following forms: a social institution that contributes to the health of the population as a whole and not just the individual's health; a social institution that by being accessible to all, contributes to the idea of living in and helping to build a caring society (a form of social option value); and a social institution that, by being amenable to the preferences of citizens, enhances democracy." (Mooney, 2009: 175).

He frequently used the concept of compassion to highlight how the health system as a social institution can impact on societal values. Drawing on Nussbaum's work, he noted that "compassionate individuals construct institutions that embody what they imagine; and institutions, in turn, influence the development of compassion in individuals" and called for the development of "compassionate institutions" (Mooney, 2012b).

He strongly believed that in divided societies, the health system could lead the way in promoting unity. Referring to his own country, South Africa, he argued that the proposed tax-funded universal health care system "... will be a social institution that can help to build a more united country and show the way to create other socially uniting institutions in this deeply fractured country" (Mooney, 2012a: 138). This resonates with my own view that the importance of the proposed health sector reforms in South Africa lies not only in improved access to needed health services for all but also in its potential to contribute to building social solidarity.

4. Global health

One of the last e-mails I received from Garth Mooney was to share the following information: "The top richest individuals of the world have economically recovered from the global financial crisis and its aftermath. They are now actually wealthier than five years ago. ... this group had their wealth almost halved between 2008 and 2009. However, this proved to be just a temporary slump as all their losses were recovered in just two years. If people in poverty could also recover like that, it would be easy to eradicate poverty. ... The wealth of the 17 richest individuals is enough to reflect the annual wealth of the 1.3 billion poorest people ... the wealth of the richest 140 individuals (or families in few cases) is enough to mirror the combined 'wealth' of all the three billion people in poverty" (Kellequah, 2012). Based on these and other similar findings on increasing inequalities he noted that "health inequalities across the globe remain massive" and that "poverty and inequality remain the world's greatest killers" (Mooney, 2012b).

There is considerable commonality in Mooney's diagnoses of the health and health system problems and suggested solutions at national and global levels. For example, the above quote highlights the emphasis that Gavín placed on the social determinants of health when considering health inequalities, not only within but also between countries. In the global context, he particularly denounced neoliberal ideology and the institutions that promoted it: "The problems of individualisation that plague ... the social determinants of health in individual states are at least as prevalent when the focus moves to the international stage with, at that level, the increasing hegemony of neo-liberalism, as promoted currently by our global institutions" (Mooney, 2009: 183).

He notes that these "... growing wealth and health inequalities within and between countries, ... have been increasingly attributed to the unequal distribution of benefits arising from neoliberal globalisation" (Gavender and Mooney, 2012: e93). He highlighted that the policies of organisations such as the World Bank, the International Monetary Fund and the World Trade Organisation had contributed to a skewed distribution of benefits from economic globalisation. As but one example, he quotes Stiglitz, a former Vice-President of the World Bank: "RIPPS reflected the triumph of corporate interests in the United States and Europe over the broader interests of billions of people in the developing world. It was another instance in which more weight was given to profits than to other basic values—like the environment, or life itself" (Stiglitz, 2013: 195).

Stiglitz's quote also points to another critique that Mooney levelling at these global institutions, namely that they are driven by governments, particularly those of developed countries, and not people and that this has contributed to these institutions having mono-cultural values and advocating neo-liberal policies (Gavender and Mooney, 2012). He and Gavender went on to argue that "this domination has drowned out non-developed countries' voices and the values of the global poor and, in turn, has collectively contributed to the lack of progress in global health" (Gavender and Mooney, 2012: e93).

As he had argued in relation to national policies, so at the global level he argued that mono-culturalism and ignoring heterogeneity was problematic as it translated into imposing policies that did not take local values and cultures into account (Gavender and Mooney, 2012). It is not only important to recognise this heterogeneity to promote culturally appropriate policies in different settings, but from a social determinants perspective he argued that "... the links between culture and health point to the need to preserve the diversity of cultures across the globe" (Mooney, 2009: 171).

He argued that it was essential "... to build a more compassionate global community. There is a need for either reformed or new institutions where power is vested in the hands of people and not in governments and especially not governments of developed countries" (Gavender and Mooney, 2012: 101). There is a "need for there to be a more genuinely 'world' citizenry voice rather than, as currently, simply national governments who promote the interests of their constituents, i.e., their countries" (Mooney, 2008: 188). Once again, he proposed that health and related policies should be underpinned by community values and that a constitution for health was needed at the global level.

In addition, "at a global level, there needs to be a much greater recognition of a world community autonomy where the rich will allow the weaker nations of the world to have genuine autonomy in their own affairs. There is too little social compassion at an
international level" (Mooney, 2009: 180–181). Given the pervasiveness of individualism, he indicated that "... we need our rulers to encourage us to see the merits of altruism; not just the merits for the poor but for the rich as well" (Mooney, 2009: 186).

5. Research agenda legacy

Much of Mooney’s work reviewed in this paper could be regarded as conceptual, presenting ideas and arguments and often drawing on the work of philosophers and other social scientists rather than his ‘home’ discipline of economics. In recent years, he also adopted a political economy framework for much of his writing, for many fellow (health) economists, his articles and books which presented ideas and arguments rather than undertaking empirical economic analyses raised questions about the ‘evidence base’ underlying his proposals and prompted comments such as: “this is a nice idea, but how can one make it work.” While Mooney did go further than exploring concepts and presenting ideas to investigate how these ideas could be operationalised (such as his work on eliciting community preferences through citizens’ juries), part of the legacy he has left is quite a substantial research agenda on how to apply some of the ideas he put forward. For example, how does one negotiate the political economy within a country (and at the global level) to actualise a health system constitution based on community values? What governance structures are necessary to monitor performance of managers and policy-makers in relation to whether their decision-making reflects these values? What can be done to ‘enforce’ the constitution? What are the characteristics of health systems that are truly social institutions and that promote compassionate societies and contribute to building social solidarity? As described below, a number of opportunities are presenting themselves to begin to address this research agenda.

6. Relevance to current global discussions

Mooney’s work on social determinants of health at national and global levels, and the need for inclusive health (and other social) systems that reflect the values and preferences of people, have direct relevance for current discussions about a ‘post-2015’ sustainable development agenda. There is considerable resonance between his writing and the framework recommended by the United Nations’ (UN) ‘System Task Team on the Post-2015 UN Development Agenda (2012: i–ii) to initiate engagements around this agenda: “The central challenge of the post-2015 UN development agenda is to ensure that globalization becomes a positive force for all the world’s peoples of present and future generations. Globalization offers great opportunities, but its benefits are at present very unevenly shared. ... Persistent inequalities and struggles over scarce resources are among key determinants of situations of conflict, hunger, insecurity and violence, which in turn are key factors that hold back human development ...”. The UN Task Team went on to state that "... transformative change is needed ... which would also involve reforms of mechanisms of global governance” (2012). This correspondence of views about the key challenges and needed changes implies that there is a window of opportunity to put some of the ideas of Mooney (and like-minded people) into action.

Although the post-2015 development agenda presents a potential opportunity for transforming the global political economy landscape, we may not yet have reached a point where the stranglehold of neo-liberal governments on key global institutions will be broken. An insight into this is provided in the recently released “Report of the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda” (Co-chaired by David Cameron, Ellen Johnson Sirleaf and Dr. Susilo Bambang Yudhoyono). In this report, the emphasis is placed firmly on addressing poverty, with a call to eradicate extreme poverty and to reach "the very poorest and most excluded people", but with little focus on inequalities. While there is reference to need to provide jobs for more people to "end the inequality of opportunity", the report's contents strongly suggest that, at least in the minds of the ‘Eminent Persons’, it is merely necessary to do the bare minimum to obscure the evidence of the worst excesses of neo-Liberalism and a form of globalisation where "more weight [is] given to profits than to other basic values", but not to do anything that would fundamentally disturb the dominant neoliberal, global political economy. While the report states that there is a need to forge a new global partnership ... with a new spirit of solidarity, of concern, and mutual support, this is very far from Mooney’s vision of “reformed or new [global] institutions where power is vested in the hands of people and not in governments and especially not governments of developed countries”.

The post-2015 development agenda discussions are not over, and there is still time to advocate for more fundamental changes to the global political economy than are being put forward by some government leaders. From a public health perspective, there certainly are opportunities to push the boundaries of the post-2015 health-related debates further than they have been to date and in directions that are in line with Mooney’s vision. From a social determinants perspective, the health sector should be more active in advocating for a ‘health in all policies’ approach, in that health should feature quite prominently in the post-2015 development agenda components related to promoting inclusive economic development, environmental sustainability and peace and security. This should be done from an explicit political-economy of the health perspective, which can be backed up with empirical evidence, such as highlighting the impact of foreign acquisition of arable land for biofuel production on the right to decent nutrition and the implications of tax avoidance by global corporations on low- and middle-income countries’ ability to devote government funds to health and other social services. Policy makers and practitioners should also be strongly advocating for an agenda that will reduce inequalities in health outcomes within and across countries as well as promote inclusive health systems that provide access to needed health care, of sufficient quality to be effective, and financial protection from the costs of health services for all people. In this regard, it will be important to heed Mooney’s words that we should not adopt a ‘one size fits all’ mono-cultural approach, but this should not be interpreted as an ‘anything goes’ approach (Kutzin, 2012), which could allow governments to abrogate their responsibilities. Rather we should seize the opportunity presented by current debates about striving for universal health systems (within the post-2013 discussions and more generally) to push for each and every country to move towards health systems that are built on values determined by their citizens and are social institutions that build solidarity, redress inequalities and unite fractured societies.

7. Notes

1. Neo-Liberalism can be defined in different ways. Mooney’s understanding of this concept is best illustrated by this quote from Harvey (2005: 2) that Mooney included in his most recent book (Mooney, 2012: 34): “... a theory of political economy practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets and free trade ... State interventions in markets ... must be kept to a bare minimum.”
2. TRIPS stands for Trade Related aspects of Intellectual Property Rights, and requires all countries that are members of the World Trade Organisation to introduce laws that protect intellectual property rights, such as through the patenting of medicines.

Ethics approval/statement

EA not required

As this is a review of aspects of the published work of Gavin Mooney, no ethics approval was required.

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Gavin Mooney
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