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**SPECIAL FEATURE:**  
**SYMPOSIUM ON ‘WHOSE HEALTH  
SERVICE IS IT ANYWAY?’**

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### **Editorial Introduction**

The contributions to this special issue have collectively demonstrated that health systems are constitutive of the political economic context in which they operate. From this perspective, the capacity to enjoy a healthy life is determined by healthcare systems, as well as factors in the physical environment (such as pollution, energy and the quality of agricultural land) and social environment (such as the level of inequality and unemployment, and access to quality food, housing and transportation). Concomitantly, the significance of power relationships is particularly pertinent. Both health and health care function at the confluence of myriad interests in contemporary capitalism, such as states, domestic and international healthcare industries, global institutions such as the World Trade Organisation, dominant providers such as the medical professions and other corporate interests such as insurance companies. Thus, rather than being reduced to questions of individual lifestyle, biomedical factors or government policies, health and healthcare are entwined with economic processes, as well as the social, political and ecological systems in which these processes are embedded (see also Chernomas and Hudson 2013).

This insight suggests that questions of ‘health’ are also inexorably interrelated to normative questions of what constitutes a ‘good society’. What are the political economic conditions necessary for engendering positive health outcomes and how should these conditions be fostered? As this special issue has already evidenced in detail, the neoliberalisation of the Australian health system has sought to institutionalise and legitimise a transition from its historic status as a primarily ‘public good’ and toward its potential as a site of accumulation. In turn, as highlighted in Ben Spies-Butcher’s article, this process has destabilised many of the positive social determinants of health and social institutions which may have protected health from the negative influence of diminished social structures. In the case of the latter, the recommodification of public health

has been of particular significance. Public health has increasingly been represented as a commodity like any other, especially through its articulation with neoliberal tropes such as ‘cost-sustainability’ and ‘efficiency’. Key policy reforms, such as those contained in the 2014-15 Federal Budget (Commonwealth Government 2014), portray the former as a categorical necessity because health costs are assumed to be rising inexorably. Such rising costs are attributed to the presumed discrepancy between the demand for healthcare being infinite and finite public spending claimed to *already* be at the limits of affordability. This makes efficiency all-the-more important – an objective presented as able to be achieved only through marketisation and privatisation of provision processes (Leys 2009). In turn, the relation between public health and the conceptualisations of the ‘good society’ have largely been submerged in debates focussing on these twin ‘imperatives’, while the structural factors that condition health outcomes – inequality, food, housing, climate change, unemployment, occupational health and safety – have been left largely untouched.

The following symposium, revolving around a seminal article by the late Gavin Mooney and Scott Blackwell, is particularly pertinent in this context. The inclusion of Mooney and Scott’s contribution, as well as the three brief reflections that follow it, is intended to recontextualise public health as a site of struggle: between commercial actors seeking to commodify it and popular forces advocating for it to remain as a public service and to reduce issues of inequalities of access. The symposium thus seeks to refocus debate over public health away from the assumption that it must inexorably be geared toward profit and administered in a top-down, technocratic manner. Instead, it prompts consideration of alternative health arrangements prioritising the promotion of health as a public good – whether along the lines advanced by the article or other directions grounded in the decommodification of health systems (Deppe 2009).

To this end, the symposium begins with Mooney and Scott’s article, which poses the important question: how might an alternative model of public health be conceptualised, particularly one based on more democratic principles? Recognising that healthcare is best understood as a social institution, it presents the case for a more *communitarian* approach to health systems through a consideration of the concept of ‘citizens’ juries’ (see also the previous article in this issue by Simpson, Guthrie and Butler for a discussion of this concept and role of the public in health

systems). From this perspective, societies must become more genuinely democratic through greater public participation in the decision making processes which establish principles and priorities for health and healthcare (see Mooney 2012). The article is then followed by the commentaries of three prominent public health scholars – Pat Neuwelt, Peter Sainsbury and David Legge – who each reflect on the pertinence of the ideas presented in the article. In addition to considering the merits of the alternative presented by Mooney and Scott as means to achieve an institutional shift in power relations, these contribution also emphasise how an increased focus on community and participation itself is likely to be health-enhancing. Finally, each piece also offers personal reflections on the scholarly and practical contributions of Gavin Mooney to the political economy of health.

*David Primrose*

*Dorothy Broom*

## References

- Chernomas, R. and I. Hudson (2013), *To Live and Die in America: Class, Power, Health and Healthcare*, Pluto Press, London.
- Commonwealth Government (2014), *Budget 2014-15: Health*, Commonwealth of Australia, Canberra.
- Deppe, H-U. (2009), 'The Nature of Healthcare: Commodification versus Solidarity', in L. Panitch and C. Leys (eds), *Socialist Register 2010: Morbid Symptoms – Health Under Capitalism*, Merlin Press, Pontypool, pp. 29-38.
- Leys, C. (2009), 'Health, Healthcare and Capitalism', in L. Panitch and C. Leys (eds), *Socialist Register 2010: Morbid Symptoms – Health Under Capitalism*, Merlin Press, Pontypool, pp. 1-28.
- Mooney, G. (2012), *The Health of Nations: Towards a New Political Economy*, Zed Books, London.

## **WHOSE HEALTH SERVICE IS IT ANYWAY? COMMUNITY VALUES IN HEALTHCARE<sup>1</sup>**

**Gavin Mooney and Scott Blackwell**

Who influences the shape of our health services? Many Australian citizens seem to want more health services than are currently available. There may well be many other ‘stakeholders’ – politicians, doctors, nurses, patients, patient advocacy groups, or the media – who agree with this wish, but this doesn’t stop governments holding a tight rein on health spending. Furthermore, healthcare spending decisions made within budgetary constraints are not generally made in close consultation with the community. Here we examine the arguments for drawing the community into the decision-making process. How can we elicit community values (drawing a distinction between the community and consumers) and at what level and over what issues might the opinions of the community be used to guide decisions?

### **Citizens’ Juries**

Citizens’ juries are one way of introducing greater democracy into health service decision making. In 2000 and again in 2001, under the auspices of the Medical Council of Western Australia, citizens’ juries were trialled in Western Australia (Medical Council of Western Australia 2000, 2001). To date these are the only two instances when such juries looked at health issues in Australia.

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<sup>1</sup> This article originally appeared as Mooney, G.H. and S.H. Blackwell (2004), ‘Whose Health Service is it Anyway? Community Values in Healthcare’, *Medical Journal of Australia*, Vol. 180, No. 2, pp. 76-8. © Copyright 2004 The Medical Journal of Australia - reproduced with permission. The article has been modified in no way other than switching from a system of endnotes to in-text referencing and the related inclusion of a bibliography to comply with the guidelines of the *Journal of Australian Political Economy*.

The principles underpinning the citizens' juries were:

- random selection – of citizens of WA without any specific 'axe to grind', drawn randomly from the WA electoral roll
- being community focused – jurors were asked to deliberate and make decisions for the whole community, not just themselves as individuals
- balance – the witnesses giving evidence to the jury have to provide a balanced view
- deliberation – time to discuss, ask questions and make decisions.

The first jury met in March 2000 in tandem with a health industry conference on health and economics and its recommendations were that there be:

- greater priority setting in health
- equity, based on equal access for equal need
- positive discrimination for disadvantaged people
- more spending on prevention and public health ahead of treatment of disease
- more spending for rural and remote health ahead of urban health
- more of a focus on community based health services (Medical Council of Western Australia 2000).

The second jury met in February 2001 and focused on equity, one of the priorities identified by the 2000 jury. The citizens on the 2001 jury began by deliberating on a concept of equity in health services. This was agreed to be equal access for equal need, where equality of access means that two or more groups face barriers of the same height and where the judgement of the heights is made by each group for their own group; and where nominally equal benefits may be weighted according to social preferences, such that the benefits to more disadvantaged groups may have a higher weight attached to them than those to the better-off groups.

The jury then applied this principle to three areas of inequity in WA health services:

- Aboriginal versus non-Aboriginal healthcare
- rural and remote healthcare versus urban healthcare

- aged versus other healthcare.

The jury was 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. This they were able to do, giving greatest priority to reducing inequities in Aboriginal health.

The jury procedure is a way of discovering community values in a context that supports informed decision making (unlike, for example, opinion polls). In eliciting these values, there is an important distinction to be drawn between the community and consumers of healthcare services. The former involves citizens; the latter largely patients. Clearly, individuals can be, and often are, both. Citizens include patients, potential patients, taxpayers and insurance premium payers. Citizens' values are more likely than patients' values to embrace interests in others in the society. Equity, for example, may be of little concern to the patient; it is more likely to figure in the mindset of the citizen.

Thus the input of citizens' juries is different from 'health consumer' advice, which usually comes with a specific focus or 'axe to grind'. Consumer input is best applied to diabetic care or timing the opening of the GP surgery. The community has a broader vision — more detached, more social, and more considerate of the needs of others.

'Community' is a term that can embrace different groupings. These will normally be geographical (eg, town, state, nation) but can also be socially defined (eg, the Aboriginal community, the gay community). An individual can belong to more than one community. Which community to select when eliciting preferences will be a function of which decisions are being analysed and who is affected by these decisions.

Two clear messages arise from the experience with citizens' juries. Firstly, that through this process the community can give meaningful advice on broad issues underlying health resource allocation. Secondly, that citizens' juries are capable of dealing with some big issues conceptually (the sophistication of their equity definition is testimony to that!) and practically.

Since these jury events, the Osborne Division of General Practice in Perth has sought the community view using a similar process.

## Means of Public Participation

Mort and Harrison suggest that 'being in favour of public participation is rather like being against sin; it is hard to find disagreement' (Mort and Harrison 1999). While in recent years there has been growing interest in involving the community in health service planning and decision making, such participation has a lengthening history dating back for at least half a century. One might argue that the idea goes back much further, to the age of enlightenment, when Rousseau (1762) wrote of his ideal society: 'Bands of peasants are seen regulating affairs of state under an oak, and always acting wisely.'

## Some Milestones in Public Participation

**1954:** WHO (1954) recommends involvement of the general public in health education policy making;

**1977:** UN report (1977) sees public participation as a central tenet of primary health care;

**1984:** World Federation of Public Health Associations calls for public participation in primary health care to build on local knowledge (Vuori 1984);

**Early 1990s:** Public involvement in setting health service priorities in New Zealand (Cumming 1994);

**1994:** Oregon makes first explicit attempt at health care rationing in the US (Kitzhaber 1993);

**1995:** WHO (1995) reaffirms the importance of community participation in health promotion;

**1990s:** Citizens' juries in the UK (Leneghan 1999).

Scarcity of resources is a fact of healthcare. This needs to be recognised by the potential respondents to any community survey, thereby avoiding 'wish listing' in an environment where the opportunity costs of choices are not apparent. The sorts of choices they should face are those that health service planners face: whether to spend more or less on interventions in maternity care or the mentally ill; more or less on urban, rural or remote healthcare; on the young or the old; on Aboriginal or non-Aboriginal healthcare.

In the literature there is little discussion on what approach to use in eliciting community preferences. Is the intention to obtain community values by aggregating the preferences of individuals concerned for themselves? Or by asking individuals to put themselves in the position of planners acting on behalf of a community such as, say, the Perth community or the Australian community? Or are community values best discovered by allowing a communal discourse that gradually reveals a consensus? Each approach is likely to reveal a different set of community preferences. The usefulness of each approach will be partly dependent on what kind of decision making the results are intended to guide.

Dolan *et al.* (1993) consider three perspectives:

- personal – value to the individual self
- social – value to others
- socially inclusive personal – value to others plus self.

A fourth is the ‘communitarian’ perspective (Black and Mooney 2003), where the community and not an aggregation of individuals might be the focus. The Perth citizens’ juries, where consensus was sought rather than the sum of individuals’ votes, might be seen in these terms.

There are various techniques available for finding community values. In addition to citizens’ juries, these include deliberative democracy, focus groups, opinion polls, conjoint analysis and several others (Bowling 1996; Dolan *et al.* 1999; Ryan *et al.* 2001; Wiseman *et al.* 2003). There is too little evaluation of these to judge which is best. Such a judgement may not be possible: each technique may have its place.

We recommend that any process for eliciting community values should provide:

- sufficient information (because the exercise of preferences must be well informed)
- opportunity for respondents to reflect and deliberate
- recognition of the scarcity of health service resources (because preferences are truly revealed when one is required to make a choice).

Expert views or medical specialist knowledge may be important inputs, providing information that is then filtered through a random group of



citizens engaged in deliberation and reflection. Such a process allows the social context to be added to medical science.

Many decisions in healthcare are complex and technical. At the clinical level, society trains doctors to act as patients' agents to allow the patient (or sometimes the doctor on behalf of the patient) to make decisions that are more informed than those of the patient alone. Above the level of individual clinical decisions, there are questions of resource allocation and policy that are very much social choices. They still have to be informed by technical information. In between, doctors are faced with many decisions where it is less clear which values should apply. Partly this is because it is difficult to decide where the dividing line should come between professional and social value judgments; partly because some decisions are so technical and complex that citizens cannot make truly informed choices. However, citizens may accept their limitations in some areas of decision making, while insisting on their right to decide in others. Citizens may choose the issues for which they want their preferences to be counted. They may thus have 'preferences for preferences'.

This last issue has received less attention than it merits. In a study in Australia, Wiseman et al showed that citizens were keen to be involved in healthcare decision making (Wiseman *et al.* 2001), but saw this as 'involving other groups, namely clinicians, health service managers, and patients and their families'. The desire to be involved varied with the type of decision (*eg.*, citizens were less inclined to want to be involved in decision making 'concerning specific medical procedures').

We would argue that the sorts of decisions for which health services should seek to discover community preferences are those:

- for which citizens can be given adequate information at not too high a cost
- in which they themselves have a preference for being involved.

These principles point to more community involvement at the broader level, such as in determining the principles that underlie healthcare services in general, or what has been called 'a constitution' for health services (Mooney and Wiseman 2000).

## Conclusion

There are various problems with seeking community preferences to guide healthcare: the time taken to achieve consensus, the difficulties in establishing informed choice, the tendency for pressure groups and interested parties to outweigh the silent majority, and so on. None, we believe, is insurmountable. There are issues of broad principle (such as equity) that do seem to be best handled by referring to community values. How best to elicit such values remains subject to debate and requires more research. Exactly which decisions, to what extent and in what way, should be influenced by community values will (we suspect) always be a contentious question and will not necessarily be answered in the same way in all health service jurisdictions. Citizens' juries are one way forward. The best approach will vary depending on the questions being asked, the community concerned and the resources available. However, we would submit that the need for good information, choices constrained by resources, and time to reflect are requirements of any process for eliciting community values.

*Gavin H. Mooney held professorships at numerous universities throughout the world throughout his career. He was also the author of over 200 publications, 23 books and was regarded as one of the world's leading health economics educators across generations.*

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## References

- Black M. and G. Mooney (2002). 'Equity in health care from a communitarian standpoint'. *Health Care Analysis*; 10: 193-208.
- Bowling A. (1996). 'Health care rationing: the public's debate'. *British Medical Journal*; 312: 670-674.
- Cumming J. (1994). *Core services and priority setting: the New Zealand experience. Health Policy*; 29: 41-60.
- Dolan P, R. Cookson and B. Ferguson (1999). 'Effect of discussion and deliberation on the public's views of priority setting in health care: focus group study'. *British Medical Journal*; 318: 916-919.

Dolan P, J.A. Olsen, P. Menzel and J. Richardson (2003). 'An inquiry into the different perspectives that can be used when eliciting preferences in health'. *Health Economics*; 12: 545-552.

Kitzhaber J.A. (1993). 'Prioritising health services in an era of limits: the Oregon experience'. *British Medical Journal*; 307: 373-377.

Leneghan J. (1999). 'Involving the public in rationing decisions. The experience of citizens' juries'. *Health Policy*; 49: 45-61.

Medical Council of Western Australia (2000). *Health and economics – bridging the abyss*. Perth: Health Department of Western Australia.

Medical Council of Western Australia (2001). *Citizens' jury 2001. What's fair in health care*. Perth: Health Department of Western Australia.

Mooney G. and V. Wiseman (2000). 'A constitution for health services'. *Journal of Health Services Research and Policy*; 4: 1-2.

Mort M and S. Harrison (1999). 'Healthcare users, the public and the consultation industry'. In: T Ling (ed.). *Reforming healthcare by consent: involving those who matter*. Oxford: Radcliffe Medical Press.

Rousseau J-J (1762). *The social contract*. Translated by GDH Cole, revised edition. London: J M Dent.

Ryan M., D. Scott and C. Reeves *et al.* (2001). 'Eliciting public preferences for health care: a systematic review of techniques'. *Health Technology Assessment*; 5: 5-15.

United Nations (1977). *Community involvement in primary health care. A study of the process of community motivation and continued participation*. Report for the 1977 UNICEF-WHO Joint Committee on Health Policy, 21st Session. WHO: Geneva.

Vuori H. (1984). 'Overview — community participation in primary health care: a means or end? IV. International Congress of the World Federation of Public Health Associations'. *Public Health Review*; 12: 331-339.

Wiseman V., G. Mooney, G. Berry and K.C. Tang (2003). 'Involving the general public in priority setting: experiences from Australia'. *Social Science and Medicine*; 56: 1001-1012.

World Health Organization (1954). *Report of the Expert Committee on the Health Education of the Public*. Technical Report Series 89. WHO: Geneva.

World Health Organization (1995). *Renewing the health for all strategy*. WHO: Geneva.

### ***Commentary One: Pat Neuwelt***

The research and writing of Gavin Mooney, health economist and public health academic, has been influential in my development as a researcher and educator. This *Medical Journal of Australia* Viewpoint article was especially helpful to me during my PhD.

Between 2002 and 2007, I undertook research on the topic of community participation in primary health care in the New Zealand health sector (Neuwelt *et al.* 2005). The first major strategy on primary health care had just been released in New Zealand, calling for significant reform of primary care. The reform included the establishment of not-for-profit primary health organisations (PHOs) within which general practices would sit, and the involvement of consumers, communities and representatives of Iwi (Māori tribes) in PHO governing processes. Community and Iwi participation in healthcare governance has been well known in the New Zealand community-controlled sector (Māori, Pacific and Union health services) since the 1980s. However, the idea of community involvement in ‘mainstream’ primary care was deemed radical by many in the sector in 2001, and still is.

My national study of stakeholder perspectives on community participation revealed striking contrasts in viewpoints. Policymakers, public health professionals and members of the community-controlled sector all recognised distinctions between community, patient, or clinician views. Apart from those working in the community-controlled sector, general medical practitioners (GPs) did not (Neuwelt 2012). Many GPs argued that patient satisfaction surveys, carried out as part of practice accreditation, represented community involvement in their practices. Some argued that, as GPs in small communities, they could represent community views themselves (‘I’m a member of this community too’). The conflation of patient and community voice was evident and needed further unpacking.

That’s when I came across this article by Mooney and Blackwell. What a relief it was to find that someone was well ahead of me in exploring these issues. Gavin Mooney and a range of colleagues had been working with citizens’ juries in Western Australia to explore citizen involvement in health care prioritization. As reported in this article, their research had been undertaken in 2000 and 2001, and had elucidated some important

distinctions between ‘community’ and ‘consumer’ (patient) values. The statement I have often quoted from this paper is:

Citizens’ values are more likely than patients’ values to embrace interests in others in the society. Equity, for example, may be of little concern to the patient; it is more likely to figure in the mindset of the citizen.

They identified that patients are more likely to be single-issue focused, without consideration of social issues. While a patient perspective is valid for clinical decision-making, policy decisions ‘are very much social choices’. Mooney and Blackwell’s paper offered a turning point in my research. It provided the evidence I needed to argue for *communal* discussion and deliberation over primary health care planning, which involved not only ‘consumers’ but also citizens or community members.

The paper makes an argument that is as valuable in today’s health policy climate as it was ten years ago. ‘Patient-centred care’ is forefront in the healthcare quality agenda. The idea that people, as citizens and not only as consumers, can and should contribute to healthcare planning has gone. In 2004, Mooney and Blackwell were addressing neoliberalism in health policy. They challenged the (neoliberal) discourse of individualism, which excludes community (or ‘social’) values, such as equity. In a neoliberal agenda, scarcity and complexity become arguments against involving citizens in healthcare planning. The privileging of specialist medical views (and managers) is rife. Yet, Mooney and Blackwell provided evidence to suggest that, if well informed, citizens are fully capable of engaging in deliberative decision-making, to allow ‘the social context to be added to the medical science’.

What’s so important about Mooney’s citizens’ jury research is that it explored values. Much health services research is carried out as if in a ‘value-free zone’, and yet it reflects the values underpinning neoliberalism. Individualism is valued above collectivism. Economic efficiency is valued above actual service effectiveness. ‘The economy’ is valued above people. Yet, surely an economy is intended to serve people, and not the other way around.

It was a surprise for me to discover that Gavin Mooney was an economist! This article attests to the fact that he placed people ahead of ‘the economy’. In current times, when many governments value economic development above all else, Gavin’s work can continue to

challenge the status quo in modern political processes. The current Trans Pacific Partnership (TPP) international trade negotiations are a case in point. Australia, New Zealand and ten other nations have been negotiating a very restrictive, TRIPS-plus trade agreement between Pacific Rim nations over the past five years. The contents of the negotiations have been kept secret from all except corporate stakeholders, with no opportunity for genuine and well-informed public debate about what's at stake. The impacts of the TPP are likely to be highly inequitable (e.g. limitations on government's ability to regulate to control the costs of medicines, to include warning labels on alcohol, to phase out tobacco consumption) (Gleeson and Friel 2013). Again, neoliberalism at play with no consideration of citizen's values. Where is the concern for equity? Where, in fact, is democratic process?

I have no doubt that Gavin Mooney would have much to say about the current state of affairs in politics (Australia, New Zealand and elsewhere), healthcare prioritization, and international trade negotiations. I'm only sorry that his significant contribution to public health and health services research ended prematurely. It's up to those of us inspired by his work to continue intelligently questioning – both as researchers and as citizens.

*Pat Neuwelt is a public health physician, general practitioner and Senior Lecturer in Public Health in the School of Population Health at the University of Auckland. She is also a member of the People's Health Movement.*

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## References

- Gleeson, D. and S. Friel (2013), 'Emerging threats to public health from regional trade agreements', *The Lancet*, Vol. 381, No. 9876, pp. 1507-9.
- Neuwelt, P., P. Crampton, S. Crengle, K. Dew, A. Dowell, R.A. Kearns *et al.* (2005), 'Assessing and developing community participation in primary health care in Aotearoa New Zealand: A national study', *New Zealand Medical Journal*, Vol. 118, No. 1218.
- Neuwelt, P. (2012), 'Community participation in primary care: what does it mean "in practice"?' *Journal of Primary Health Care*, Vol.4, No. 1, pp. 30-8.

### ***Commentary Two: Peter Sainsbury***

Gavin Mooney will be remembered by many for his passionate and very active commitment to social justice and for working *with* disadvantaged and oppressed people to help them have a voice. He would speak *for* unrepresented people if that was the only option but he much preferred helping voiceless or unheard people to speak for themselves. His early adoption and trialling of citizens' juries was a very practical expression of this, and of his firm belief in communitarianism, the primacy of shared community values rather than atomised individual preferences in collective decision making and action. From his early experiments with citizens' juries in Western Australia, Mooney continued to advocate for and use citizens' juries for the next decade.

I have the impression that more people - public servants, academics and members of the public - are aware of, and have run or participated in, citizens' juries now than 10 years ago. I have refereed for peer-reviewed publications one or two papers that have used citizens' juries. However, they have certainly not become a routine component of public decision making processes in Australia. I believe that this is because politicians and government bureaucracies remain reluctant to enter into any truly participative decision making. They might be prepared to use a citizens' jury, or an alternative participative democratic process, to inform a decision about a particular issue but they have not shown any willingness to let citizens' juries make any decisions or to incorporate citizens' juries into routine policy-setting practice. Mooney and Blackwell (2004) recognised that some decisions are extremely technical but also that 'citizens may accept their limitations in some areas of decision making [...] and may choose the issues for which they want their preferences to be counted'; calling this having 'preferences for preferences'. Selecting where to increase one's bargaining power among a range of issues chosen by others is certainly a more progressive application of community involvement in decision making than is usual in Australia but it is still limited to Lukes's (1974) first dimension of power. It does not tackle Lukes's second dimension (the ability to determine the issues that will and will not be debated), let alone his third dimension, being able to identify and pursue one's 'real' interests which may be obscured by the covert actions of existing power elites.

Mooney and Blackwell saw ‘the tendency for pressure groups and interested parties to outweigh the silent majority’ as a problem associated with community consultation. The opposite risk is equally present though: that by making decisions through consensus (majority rule following informed debate) citizens’ juries may result in the suppression of minorities’ interests. This ‘tyranny of the majority’ is already a problem in western-style representative democracies which developed between the late eighteenth and late twentieth centuries in response to demands for more representative government generated by, for example, the enlightenment, industrialisation, urbanisation and colonialism, and there is a risk that citizens’ juries (while perhaps being more participative than an occasional vote to choose between two or more possible representatives) will amplify this problem. In fairness to Mooney though, he would be greatly distressed if citizens’ juries did not give oppressed minority groups, of whom he was a great friend and champion, not only a voice and a place by right in decision making but also recognition of their legitimate needs and demands in the resulting policies and their application.

Another of Mooney’s interests, to which passing reference is made in the reprinted paper, was a constitution for health services – a set of principles for health service delivery that would be developed in part through community consultation and would form a basis for a nation’s health services. A similar idea at the international level has recently been promoted by Gostin *et al.* (2013) who call for ‘[the] adoption of a legally binding global health treaty – a framework convention on global health grounded in the right to health’. The convention would ‘reduce health disadvantages experienced by the marginalized and the poor’ and would ‘advance health justice through engaging marginalized and underserved populations in making and evaluating policies’. Gostin and colleagues call for the convention to be embedded in national laws so that civil society can litigate for the right to health and compete with legal regimes covering, for instance, trade and investments.

To illustrate some of Mooney’s interests in a contemporary context, Australia is at the time of writing negotiating the Trans Pacific Partnership Agreement (TPPA), a multinational trade agreement with eleven other developed and developing Pacific nations (not including China), the biggest and most powerful of which is the USA (Gleeson and Friel 2013). The American negotiators are pushing hard for an Investor-State Dispute Settlement (ISDS) mechanism in the TPPA. This would



allow corporations to take national governments to an international court if laws are enacted or policies introduced that limit the corporation's ability to conduct their business. For instance, if laws are introduced that, in the interests of public health, limit the promotion or sale of tobacco products a tobacco company can claim that this is contrary to the requirement of the TPPA to promote free trade and can seek financial damages. The previous Labor government made it clear that it would not accept an ISDS clause in the TPPA applying to Australia but the new Coalition government has indicated that it is prepared to negotiate on this point. It would be interesting to ask Australian citizens' juries to consider the ISDS. I would wager that most citizens would express total amazement that a private company could sue a government for acting in the citizens' interests. Rather than endorsing an ISDS, I suspect that most citizens would prefer governments to be able to sue corporations for compensation for their selfish and reckless promotion of products that harm human health. A convention similar to that proposed by Gostin and colleagues would even allow citizens to sue their government for failing to act in such a manner. Gavin Mooney would be up for that.

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## References

- Gleeson, D. and S. and Friel (2013), 'Emerging threats to public health from regional trade agreements', *The Lancet*, Vol. 381, No. 9876, pp. 1507-9.
- Gostin, L.O., E.A. Friedman and K. Buse *et al.* (2013), 'Towards a framework convention on global health', *Bulletin of the World Health Organization*, Vol. 91, pp. 790-3.
- Lukes, S. (1974), *Power: A Radical View*, Macmillan, London.

### Commentary Three: David Legge

Gavin Mooney was loved and respected for many reasons; not least his passion, anger, integrity and blunt speaking (Sweet 2012; McIntyre *et al.* 2013; Navarro 2013; Wodak and McIntyre 2013). The circumstances of Gavin's and Del's deaths deepens the tragedy of their loss, of our loss (Soares 2012).

In his 2004 paper on citizens' juries (Mooney and Blackwell 2004) Gavin returned to a problem which had engaged him from early in his career: how to allocate health care resources efficiently and fairly. The paper, reproduced in this issue of *JAPE*, demonstrates that, '[w]hen asked to take a community focus, presented with balanced evidence and given time to discuss and deliberate, the juries were able to identify and debate issues of broad principle, such as equity'. The paper argues that '[T]he jury procedure is a way of discovering community values in a context that supports informed decision making'.

The reference to 'community values' here links this paper to Gavin's own professional (and personal) journey from his 1977 book and paper on the need to assign values to human life (Card and Mooney 1977; Mooney 1977) to his later books, in particular Mooney (2009) and Mooney (2012), in which he railed against the conceptual limitations which he judged were limiting the contribution of health economics to health decision making.

In particular he was critical of the established discipline for its preoccupation with measurement and for its methodological individualism in conceptualising health decision making. Beyond methodology he was critical of the neglect, within health economics, of the political economy tradition; the need to understand the power relations of health care resource allocation and the politics which shape the social determinants of health. He called for more attention to the political economy of health, rather than just health care, and to the political economy of hunger as well as obesity.

The intensity of Gavin's critique of his own discipline corresponds in some degree to the pathway which his own professional exploration took.

The 1977 paper (Card and Mooney 1977) is quite clear in its advocacy of explicit monetary valuation of human life, including an overview of different ways of eliciting individual values. 'But the valuation of human

life should be made more rational and explicit. There is nothing inhumane in this. By doing so the quality and quantity of health care is likely to be increased, and the onus is on those who remain unconvinced to put forward an alternative scheme.’ In this paper three ways of assigning a monetary value to human life are considered: productivity, inference from practice and ‘willingness to pay’.

By 1998, Gavin was elaborating a much more nuanced approach to community preferences, embodied in his concept of ‘communitarian claims’ which also underpins the 2004 paper. In this system the community makes judgements regarding resource allocation which go beyond any standardised valuation of a life year or a standardised adjustment for ‘quality of life’. Rather the community is able to express preferences regarding equity (*e.g.* justifying extra resources because of disadvantage or because of colonial dispossession) in addition to concern for the quality of life years gained. However, there is still an assumption here that the community preferences so elicited will somehow feed into a technocratic decision process, much as individual preferences do in more conventional cost utility analysis. It also appears that ‘the community’ in this model is being treated as a singularity without any formal treatment of the ideological assumptions and power dynamics which shape community preferences. The paper by Mooney and Blackwell imagines that random selection will yield citizens without any specific ‘axe to grind’.

Gavin’s exhortation, that the health economics profession engage with the political economy tradition (2009, 2012), takes this methodological progression to a more radical outcome; a recognition of the limits of quantified preferences and decision algorithms and instead, the need to engage directly with power. Insofar as decisions over resource allocation and population health are determined by power and profit there comes a time when the health economist might have to jettison her technocratic identity and join the political struggle for justice. This position was embodied particularly in Gavin’s advocacy around Indigenous health and health in the post-Apartheid South Africa.

Gavin’s 2012 essay *Towards a New Political Economy* (Mooney 2012) situates the challenges of equity in health decision-making and the control of global warming firmly in the struggle against the neo-liberal ascendancy. This is a fundamental challenge to health economics which

is deeply rooted in classical microeconomics and has generally avoided the challenges and complexities of macroeconomics.

The neo-liberal ascendancy, from the late 1970s, is a response, driven by the transnational capitalist class (Robinson 2004, 2012), to the structural crisis of global capitalism, a crisis of relative over-production, under-consumption and over-accumulation (Harvey 2005, 2010). It would be a fitting memorial to Gavin Mooney's passion and anger for the public health community (including its health economists) to invest more of our research, teaching and practice in the political economy of health, including the effects on health care and population health of neo-liberal globalisation.

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## References

- Card, W. I. and G. H. Mooney (1977), 'What is the monetary value of a human life?', *British Medical Journal*, Vol. 2, pp. 1627-29.
- Harvey, D. (2005), *A brief history of neoliberalism*, Oxford University Press, Oxford.
- Harvey, D. (2010), *The enigma of capital and the crises of capitalism*, Oxford University Press, Oxford and New York.
- McIntyre, D., J. Ataguba, A. Scott-Samuel and R. Bunton (2013), 'Tribute to Gavin Mooney and Del Weston', *Critical Public Health*, Vol. 23, No. 4, pp. 498-502.
- Mooney, G. (1977), *The valuation of human life*, Macmillan, London.
- Mooney, G. (1998), "'Communitarian claims" as an ethical basis for allocating health care resources', *Social Science and Medicine*, Vol. 47, No. 9, pp. 1171-80.
- Mooney, G. (2009), *Challenging health economics*, Oxford University Press, Oxford.
- Mooney, G. (2012), *The health of nations: towards a new political economy*, Zed Books, London and New York.
- Navarro, V. (2013), 'Tribute to member of the editorial board Professor Gavin Mooney', *International Journal of Health Services*, Vol. 43, No. 3, pp. 387-8.
- Robinson, W. I. (2004), *A Theory of Global Capitalism: Production, Class, and State in a Transnational World*, Johns Hopkins University Press, Baltimore, MD.
- Robinson, W. I. (2012), 'Global capitalism theory and the emergence of transnational elites', *Critical Sociology*, Vol. 38, No. 3, 349-63.

Soares, A. (2012), 'Alex's words', available online:

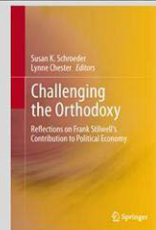
[http://www.gavinmooney.com/?page\\_id=24](http://www.gavinmooney.com/?page_id=24) (accessed: 25 December, 2013).

Sweet, M. (2012), 'A compilation of tributes to Professor Gavin Mooney and Dr Delys Weston', available online: <http://blogs.crikey.com.au/croakey/2012/12/24/a-compilation-of-tributes-to-professor-gavin-mooney-and-dr-delys-weston/> (25 December, 2013).

Wodak, A. and D. McIntyre (2013), 'Gavin Mooney (Born: 39 October 1943) and Del Weston (Born: 23 January 1950)', *Australian and New Zealand Journal of Public Health*, Vol. 37, No. 1, pp. 4-5.

## Challenging the Orthodoxy: Reflections on Frank Stilwell's Contribution to Political Economy

In April 2013, the Department of Political Economy at Sydney University held a conference to honour Emeritus Professor Frank Stilwell's career as a public intellectual and his contribution to the development of political economic thought in Australia.



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