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Commentary

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 on 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 communitarian 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.

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Introduction

Through his prolific and original contributions across numerous topics, Gavin Mooney is often considered one 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 analyses. 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 gets 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

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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, 2009; 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 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 amongst 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 that the valuation of individuals 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 though that this is a false dichotomy; practising 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, 2009). 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 outcome (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, 1994b; Mooney & Lange, 1993). 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 presently 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, 2000a, 2000b), 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, 2009; 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 of 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

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