Capabilities and Health

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Abstract

Sen's capabilities approach offers a radical generalisation of the conventional approach to welfare economics. It has been highly influential in development and a number of researchers are now beginning to explore the consequences for health-care. This paper contributes to the emerging debate by discussing two examples of such applications. First, we consider an individual decision-making level application, namely the right to die. Drawing on Nussbaum's list of capabilities, we argue that many capabilities are ambiguously or indirectly related to this right but that the ability to form a conception of the good life and plan one's own life provides a direct warrant for such a right. Second, we consider an application at the social choice level. Specifically, we focus on health-care rationing and argue that, whilst not committed to age based rationing, the capabilities approach provides a more natural justification of age related access to health-care than the fair innings argument which is often used to justify the alleged ageism inherent in QALY maximisation.

Key Terms: capabilities, medical decision making, ethics, health economics

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The Capabilities Approach – An Overview

The capabilities approach, developed first by Amartya Sen[1] and then in conjunction with Nussbaum and others[2], emerged as a response to theoretical difficulties in the conventional approach to welfare economics. One key analytical insight lay in the fact that welfare economics (whether applied to health or not) works by identifying optimal allocations of inputs and outputs whereas people are often concerned about other issues, like rights, which form legitimate claims independent of the outcomes to which they might lead.[3] In some sense, this was a surprising criticism to be able to make of welfare economics because choice is so important to economic thinking. In any case, the approach has been influential in a number of academic literatures as well as in policy-making circles concerning development and is now beginning to make substantive in-roads into the fields of health and medicine.[4,5,6,7,8,9,10]

Sen's theory, which was developed subsequently in conjunction with the philosopher and political theorist Martha Nussbaum has, at its core, the idea that what people can do (capabilities), as opposed to what they actually do (functionings), should be the focus of wellbeing evaluations and government policy. Functionings can be overly materialistic and do not allow sufficiently for the context in which they occur. For instance, someone might have a high income but be miserable. Furthermore, the choice context matters to our evaluation of the functionings that arise from that context: a person not taking food because they are fasting is regarded differently to one who cannot find anything to eat. Explicit recognition of the importance of choice contexts has been a key driver of the capability approach and though Sen has refrained from providing a list of capabilities, Martha Nussbaum has provided such a list. Her list comprises 10 items, which she elaborates to varying degrees, as follows (1.normal life span; 2. bodily health; 3. bodily integrity; 4, senses imagination and thought; 5. emotions; 6. practical reason; 7. affiliation; 8. other species; 9. play; 10. control over one's environment). She claims these are all essential for a good life though many would say they are just one account, at a fairly abstract level, of capabilities which are likely to be regarded as important though to degrees that vary.[11] We would argue, for instance, that the relative weight given to these capabilities will vary enormously with age, between people and across cultures. That said, many such lists have been drawn up by psychologists, philosophers and others and the commonalities are perhaps more striking than the differences.[12] Most development experts agree that an implication is that the state should monitor opportunities in a range of life domains such as health and education as well as income.

This approach constitutes a major generalisation compared with an approach to welfare economics that has been highly influential in health via the QALY (Quality-Adjusted Life Yearr) measure of health and the health maximisation choice rule in which the QALY is embedded. (We use QALY maximisation and health maximisation as equivalent terms henceforth.) Some of the main differences between the capabilities approach and welfare economics are as follows. First, there is an emphasis on the options people have, as opposed to the activities that they undertake. Second, the variety of capabilities which are material gives rise to a multi-variate approach to wellbeing. Third, capabilities may make interpersonal comparisons easier than is the case under some ethical approaches – many economists are willing to take for granted that interpersonal comparisons of utility are impossible. Fourth, the capabilities approach is driven partly by the inadequacy of preferences (desires) as a measure of a person's interests, particularly difficulties that arise from adaptive preferences. Potentially, all four aspects could be relevant to medical decision-making and ethics though in what follows we concentrate on implications for problems related closely to the first two of these points.

Individual Medical Decision-Making: Capabilities and the Example of a Right to Die

QALY maximisation has tended not to be used directly at the level where patient and clinician interact. Even the staunchest proponent of health maximisation would not argue that a doctor could insist that a patient take the QALY maximising treatment. The capabilities approach, by introducing an emphasis on the opportunities that a person has, makes it possible to give an account of ethical systems which value autonomy as it might feature in discussions about informed consent to the right to die. For this reason, the capabilities approach provides a conceptual apparatus that is missing from health maximisation yet necessary to describe ethical issues that are important in many medical choice problems.

To illustrate the way in which the capabilities approach might be applied, we consider the right to die. Now to be fair to the traditional approach of welfare economics, which can be regarded as one attempt to operationalise utilitarianism, one should recall that the Benthamite approach to rights was that they were 'nonsense on stilts', a phrase sometimes used to suggest that Bentham was against rights, though incorrectly. In fact, Bentham was against the idea that there were natural rights but held that people had legal rights that should be established so as to maximise overall happiness.[13] If the overall net impact on the wellbeing of patients, carers, and the medical profession were positive, then a right to die could be given a

Benthamite justification. So we should recognise that as with any right, a utilitarian justification is not impossible but is contingent on what would bring about the most overall happiness.

Now compare this with the capabilities approach, and particularly the insights that might derive from a list of capabilities such as Nussbaum's. The first three capabilities, to do with life, bodily health and bodily integrity are all potentially relevant to medical decision making in a number of ways. However, in each case, they suggest rights to positive health states in life or to duties on others to avoid bringing such health states about. In no case do they give any clear or direct indication as to what we should think in right to die cases and it is not until we move on to capability six, concerning practical reason, that we find a clear and unambiguous link. This capability concerns the ability of a person to form a conception of the good and to engage in critical reflection about the planning of one's own life. If a person had principles governing treatment in the face of severe, debilitating or terminal illness then it would be reasonable to regard those principles as part of a life plan. Capabilities concerning other species (number eight) are not obviously relevant, but this leaves five capabilities unaccounted. Capability four, concerns abilities 'to imagine think and reason…in a 'truly' human way…[and] to be able to avoid non-beneficial pain'. Clearly some right to die cases do centre around pain avoidance but those in which people are concerned about the prospects and qualities of their lives are not all such cases. So whilst capability four provides a rather direct possible justification for right to die, it has the capacity to do so, unlike capability six, only in cases where pain avoidance cannot be achieved by other interventions.

Capabilities concerning emotional expression (five) though related to four, are probably not relevant to the right to die as they concern the articulation of attitudes rather than pragmatic deliberation and choice-behaviour. This leaves capabilities concerning affiliation (seven), play (nine), and environmental control (ten). Affiliation is divided, by Nussbaum, into two parts that relate to the ability to live with, and towards, others and this too seems irrelevant. On the other hand, the second part, 'having the social bases of self-respect and non-humiliation …[which involve] being treated as a dignified being whose worth is equal to that of others' could be relevant. In some cases, a right to die would provide the social basis that patients wanting to exercise such a right feel they need to maintain their self-respect and avoid humiliation. Capability ten, the ability to control one's political and material environment adds little to the autonomy justification of a right to die which can be found in capability six but one can, at least, say that capabilities six and ten appear to argue in the same

supportive direction for such a right. The capabilities approach is not committed in general to the right to die because one could reasonably object to Nussbaum's list. However, the fact that two items on her list can be directly related to such a right, and in the same supportive direction, does seem to reflect a way in which many advocates of the capability approach would use it to form a view about rights to die.

The fact that the capabilities approach does not rule out a right to die is a feature it shares with utilitarianism and is therefore not something that can be used to distinguish between the approaches. However, utilitarianism focuses on wellbeing and mandates such a right if it promotes the total good. The capabilities approach, on the other hand, is not complete as a political theory, in the sense that it points to elements of an evaluative space without being linked to a particular method for valuing particular capabilities. (This is true even in Nussbaum's version which, by virtue of her claims about the universality of her list is more objective that most.) It seems difficult to say, therefore, that the capabilities view would necessarily argue for a right to die. On the other hand, the capabilities approach gives a structure to the concepts of capability and wellbeing which helps identify issues to which proponents of a right to die are likely to appeal. In this sense, the capabilities approach (Nussbaum's version) is more explicit about wellbeing than its utilitarian counterpart: if these capabilities, though not their relative weights, are universal, then this explicitness is valuable. So the capabilities approach gives a more detailed and direct account of factors that might be relevant to a right to die than that which we might expect to obtain from the utilitarian derived approach to welfare economics.

Capabilities, Resource Allocation and Fair Innings

As an approach to economic welfare, the capabilities approach can be expected to have insights at the macro level too. The traditional approach to welfare economics can be viewed as an attempt to operationalise utilitarianism. (In general, philosophy tends to concentrate on the identification and grammar of values whilst economics has focussed on the mathematical aspects of specification.) Health economics has developed a second interpretation (alternative but related to conventional welfare economics) of utilitarianism which does not depend on market assessments of value but uses assessments of the quality of life (QALY). It has been argued by health economists that treatments should be offered so as to maximise the total number of QALYs produced by the total population. This social choice rule, also referred to as health maximisation, is appealing until one examines, in more detail, some of its implications. In general, the view taken here (and argued for in more depth elsewhere[14]) is

that health maximisation can be justified either as a useful first order *approximation* to the social objective function for health, or as a first attempt to make ethical *principles* for health-care rationing *explicit*. However beyond that, there is room for debate, even within economics. In what follows, we discuss an aspect of the comparison between the capabilities approach and health-maximisation. The idea will be that the fair innings defence of health-maximisation is flawed, not as a justification of age related rationing, but rather as defence of health-maximisation. By contrast the capabilities approach is capable of providing a more natural and flexible justification of (ie non ageist basis for) age based rationing.

One of the implications that calls health-maximisation into question concerns the charge of 'ageism'. Health maximisation is not directly age related in that QALYs are maximised who-ever produces them, old or young. However, it is accepted that age enters indirectly, and significantly, in that young people will tend, *ceteris paribus*, to produce more QALYs. If ageism involves the inappropriate use of (old) age as a criterion for exclusion, then an important ethical question is whether the indirect age relatedness of health maximisation is ageist.[15,16,17,18] Consider the following situation. Suppose we can treat one of two people and that each, if treated, would fully recover but die otherwise. Were these patients equal in all material respects except age, then QALY maximisation would advocate treating the younger person because that person has the greater amount of life left and will generate more QALYs. A case for this is the so-called fair innings argument which holds that older people, because of the length of life they have enjoyed compared with much younger persons, should yield priority to those who are younger. The argument has been much debated but for present purposes it will be useful to mention three particular difficulties.

First, the fair innings argument only supports some of the age discriminations that QALY maximisation makes. Specifically, it applies to comparisons where the age differences between those in need are substantial and where, therefore, one party might be said to have had a fair innings and another not. However, what are we to do when making comparisons between a 35 year old and a 50 year old, say? QALY maximisation would clearly prioritise the younger patient on the grounds of her/his greater life expectancy and this could be called a form of ageism but one could hardly say that it was one justified by the fact that a 50 year old had had a fair innings. (At least fair innings arguers do not make such a claim as they put the fair innings in 70 year old mark.) The fair innings argument sets up a partial (which might also be fuzzy) ranking whilst the QALY approach is inherently complete so the fair innings argument cannot justify all the age related rationing that the health maximisation allows.

Second, a fair innings approach does not support, or at best sits awkwardly with, the sum-maximisation foundations of utilitarianism, welfare economics and health maximisation. The fair innings argument is one based on equity between individuals whereas the justification for QALY maximisation is that it does most good – so the former does not provide a justification that goes to the heart of the latter. Third, when combined with facts about life expectancy differences between men and women as Tsuchiya and Williams acknowledge[19], the fair innings argument appears to argue for prioritising the treatment of men over women and to many this consequence is very unappealing.

However, if we take a capabilities perspective, all three difficulties may be avoided. Firstly, if capabilities are to play a central role in defining the space in which actions are evaluated, then it is crucial to ask what capabilities we wish to promote. The capabilities that people actually wish to develop seem, in general, to vary across the population with respect to a number of factors. Abilities to succeed in sport, for example, depend on health status but also physical endowments which we accept, normatively, will vary. Age is another factor – and indeed recent evidence suggests that people accept a decline in mobility with age though whilst remaining unaccepting of pain.[20] These variations in the desired levels of functionings fit naturally with the view that the capabilities we expect or hope for will vary with age (amongst other variables). Proponents of the capabilities approach have emphasised the fact that this approach to ethics combines objective and subjective elements. Broadly speaking, there is a tendency to be objective with respect to the dimensions of capabilities and functionings whilst allowing the relative weights and tradeoffs between these dimensions to be subjective. So if society agreed that the acceptable levels of functioning were dependent on age and other personal factors, this could have an impact on the way in which treatments were allocated. Notice that with this approach, the capabilities view discriminates with respect to age, but for reasons that are to do with the social conception of desirable health states. Such discrimination is not self-evidently discriminatory and further arguments would have to be produced to show that such discrimination was inappropriate. Furthermore, if people did not accept that such ideals should vary with age, the capabilities approach would not able to accommodate an age indifferent approach. We would ask about the capabilities regardless of age. (However, it seems so embedded in the concept of aging that physical and mental capabilities do decline that the age indifferent seems somewhat implausible.)

Turning now to the second issue, namely that of sum-maximisation, we should note that in developing a capabilities defence of age related health-care, no appeal was made to the sum

maximisation aspect of health-maximisation. The significance of capabilities depends on the weights assigned to them, something that might be done by experts, public consultation or some combination of the two. We may wish to maximise these weighted capabilities, but by varying these weights we can obtain very different ethical prescriptions. Although from a technical viewpoint, weighted sum maximisation is not much more complicated than unweighted sum maximisation, ethically, the approaches and in terms of outcomes, the approaches could be quite different. Put another way weighted maximisation may reflect quite different ethical bases to the utilitarian approach which sum maximisation formalises.

Thirdly and finally, we turn to the issue of equity and discrimination in favour of men. There are two possibilities here, both consistent with previous remarks about variations in the social value of capabilities. One could hold that differences between men and women which gave rise to different profiles of capabilities over the life course were not such that they merited intervention. If, for example, lower life expectancy reflected the fact that more men choose to work more than women (many jobs reduce life expectancy), then the element of free choice would negate any moral pressure to reduce inequalities in life expectancy. Alternatively and by contrast, it might be argued (more plausibly to boot) that choice in matters of work force participation is constrained and that if wages and promotion opportunities were more equal between the sexes, women would choose higher levels of workforce participation. Even if this is true, it provides no reason to provide more health care resources for men. Tsuchiya and Williams, correctly in our view, argue that one has to look at the inequalities in the round, not just in the health arena. But neither the fair innings argument nor the principle of health maximation which the former was designed to support, provides a reason for looking at inequalities in the round. On the other hand, the capabilities approach, particularly Nussbaum's explicit and comprehensive version does just this.

Health Functioning and Capabilities in Other Areas of Life – A Final Consideration

As noted, the capabilities approach emphasises the multi-variate nature of human wellbeing and there are many lists of human values that share this perspective. There is a direct sense in which the QALY has a direct link to capabilities: QALYs incorporate life expectancy - and longevity appears on a number of lists of human values and indicators of human progress. However, from a multi-variate perspective it seems reasonable to suppose that core features of health-care, such as mobility and pain, also have substantial implications for both capabilities and functionings in a range of areas. Indeed, it can be argued that health status is, like income, an indicator of capability. (However, if we accept this, we should also accept that

like, income, it is a rather crude and imperfect measure. Just as some people can do more with a fixed budget, so some people are able to overcome physical incapacity better than others.)

The point is that we cannot assume that health status is independent of wellbeing in other areas of life, though the identification of a separate health component which is then maximised will only *necessarily* contribute to the maximisation of overall wellbeing if independence can be assumed. The practical significance of this point for human wellbeing depends on the empirical relationship between health states and non-health aspects of life. If the inter-relation is empirically material, the QALY measure, which looks at health status would be too narrow a measure on which to base priorities. For example, two people might have the same expected QALYs for the rest of their lives but quite different opportunities, because of their health stati, to seek and find paid employment. When it comes to deciding which of two individuals to treat, we might hold that their capacity to find work should not affect their rights to be offered treatment. On the other hand, the capability approach is consistent with the view that when it comes to the allocation of funds at a macro level, we would want to give more weight to those health-care interventions that have significant benefits both in health and non-health care terms. Perhaps the moral is that when we compare QALY maximisation and the capabilities approach, we are not comparing like with like. QALY maximisation is a theory whilst the capabilities approach is broader and better thought of as a framework from which theories can be derived.

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