

Introduction

Equity, capabilities and health

Abstract

This paper provides an introduction to a collection of articles concerning the relevance of Amartya Sen's work, the capability approach and related ethical claims, to health-care rationing.

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Amartya Sen's contributions to the social sciences are widely recognised, not least by the Nobel Prize that he was awarded in 1998. Perhaps one of the most interesting features of his work is the way in which he was able first to highlight fundamental ethical deficiencies in conventional welfare economics (Sen, 1979) and then to indicate a way, using what is now known as the capabilities approach (Sen, 1985), in which some of these problems can be resolved. The work has already been highly influential in the area of development (Stewart, 1995; Quzilbash, 1996; Alkire, 2002) and a number of researchers are now beginning to examine the implications of Sen's insights for issues in high-income countries (in health see, Anand, 2003; Anand, Peter, & Sen, forthcoming; Birch & Donaldson, 2003; Culyer, 1989; Culyer & Wagstaff, 1993; Cookson, 2003; Dolan & Olsen, 2002; Palmer & Smith, 2000; Sen, 2001; Williams, 2003). Health-care rationing, the focus of this collection, provides a particularly interesting decision (social choice) problem in which to explore these implications as the connections between theory and evidence tend to be particularly close in health economics and because there are especially strong parallels between the general reasons for wanting to reject the 'welfarist'¹ approach to welfare economics and the particular reasons people articulate for wanting to go beyond health maximisation (Anand & Wailoo, 2000; Dolan, Cookson, & Ferguson, 1999).

In the remit for this collection, authors were invited to engage with the challenges and opportunities that Sen's

views on well-being might offer to health researchers. One common theme emerges; namely, to develop normative theory (in this case an ethical approach to social choice) with an eye to empirical evidence. Whilst this fits with the emphasis currently placed on the evidence base in medicine, it is worth pointing out that the focus is the *interaction* between theory and evidence. Such work may be harder, in some senses, than just doing work which almost exclusively involves empirical investigation or pure theory development—nonetheless, it fits with many models of scientific procedure and appears capable of addressing basic questions concerning resource allocation in health.

The opening pair of papers by Brouwer et al. and Anand and Wailoo bear on Sen's distinction between well-being and 'agency', where agency goals 'encompasses the goals that a person has reason to adopt, which can inter alia, include goals other than the advancement of his or her own well-being' (Sen, 1993, p. 35). In the first paper, the health goals that a person has reason to adopt are shown to vary with age on some dimensions of health, though not on others. More specifically, Brouwer and his colleagues use the capabilities approach to motivate their study of the impact of age on the acceptability of poor health status. Their paper touches on a key question raised by the capabilities approach; namely, what are the covariates of acceptable capabilities? Equality of opportunity is an important value (see, Pattanaik & Xu, 1990; van Hees, 1999; Suzumura & Xu, 2001; Nehring & Puppe, 2002) but it also represents an ethical principle that may not be desirable in some contexts. If the capabilities that society wants to protect or promote vary with age for good ethical reasons, then resource allocation procedures

¹ Here we use welfarism to refer to social choice that excludes rights, duties, etc. and focuses only on individual well-being, however aggregated.

need to take that fact into account. In addition to the theoretical discussion, which comments on links between the capabilities approach and debates in health economics about the role of the QALY, the paper designs survey questions, using a multi-dimensional approach based on ‘health domains’, which give a measure of the extent to which ‘normal deterioration’ constitutes an acceptable, age-related change in capability. The actual survey, which draws on a nationally representative sample of Dutch adults of working age, highlights a number of points. It seems, from these data, that the concept of ‘normal’ health status changes as people age, but that extreme pain and depression are considered largely unacceptable at all ages. As the authors note, these findings would raise very important questions about the contribution of different health domains to capabilities.

In the paper by Anand and Wailoo, six aspects of procedural fairness form the basis for a survey of voters. The criteria—voice (the public’s views being heard), consistency (in the processes used to make decisions), absence of vested interests, transparency, reversibility and accuracy—were selected because of their fit with the previous theoretical and empirical literature. Respondents were asked to give importance ratings for each of these criteria when used in decision-making at clinical, regional and national level. The univariate results show that there is variation in the extent to which people believe these criteria are significant, and also that the rankings share significant similarities for each of the three levels of decision-making. Using cluster analysis, there is evidence of different internally consistent approaches to procedural fairness. A three-cluster reduction of the data is presented in which the largest group comprise individuals who, on average, are roughly neutral with respect to reversibility but who believe most of the other criteria are important. A second group is distinguished from the first mainly by virtue of the fact that members give less weight to the importance of vested interests. The third group share this distinguishing feature but add to it strong disagreement with the view that consequences should be taken into account. Whilst the authors do not argue that differential benefits are irrelevant to health-care rationing problems, they conclude that there is considerable support for an articulation of process that is consistent with the procedural emphasis that can be found in the work of political theorists such as Rawls (1971) as well as Sen (2001).

The second pair of papers turns to questions of distributive justice as they have been played out in discussions concerning the ‘fair innings’ principle. In the first of these papers, Tsuchiya and Williams address the issue of inequalities in health between females and males. Because of their shorter life expectancies on average, Tsuchiya and Williams set up their analysis by

asking whether the fair innings argument forces a favourable treatment of men over women. Six counter-arguments are surveyed and all are found to be substantially inconclusive. However, the authors do not conclude that fair innings should be used to justify discrimination in favour of men. Instead they argue that what a fair innings means should be taken in the context of well-being overall, an approach which they argue is reflected in the construction of the Human Development Index, a multivariate approach to the assessment of development which has been heavily influenced by Sen’s work. They note that, from such a perspective, there is some evidence that inequalities in income and life expectancy cancel each other out but that, in any case, a more explicit approach to inequality measurement is called for. A number of empirical parameters are discussed which, if measured, would provide us with an evidence basis for social choice based on a variety of claims to health-care, including deprivation in many domains of life.

Nord considers Sen’s comments about Williams’ (1997) fair innings argument in which Sen supports the idea of life-time measures of health deprivation but suggests that the strangeness of prioritising male health on the grounds of lower life expectancy, when compared with female health, argues for a more multi-dimensional approach to equity in health. His paper argues in similar vein, by comparing the fair innings approach to a ‘severity of condition’ approach, akin to that which emerges from the work of Brouwer et al. One of the key issues that emerges is the extent to which past suffering should be taken into account in determining a person’s entitlement to health-care—the view that it should, Nord calls a generalised fair innings account. When the issue involved is access to resources, as it is in social policy designed to alleviate financial poverty, we do tend to think that a person who has squandered or lost a fortune might be treated differently to one who has always been poor, even if it is difficult to reflect such sensitivities in policies. But perhaps health is different in this regard. Perhaps current and future pains concern society. It would certainly be useful to determine empirically how people feel though it would be equally interesting to see how different ethical theories treat the problem.

The penultimate paper, by Gavin Mooney, develops the social choice approach to health-care rationing by using a communitarian perspective. Mooney suggests that the distinction between actual desires and measures of value, which Sen makes from a general perspective, can fruitfully be applied to questions concerning the valuation of health and that, where improved health is not valued, it might be seen as a merit good. He reviews Nussbaum’s (2001) list of capabilities and suggests that a similar, though shorter, list can be drawn up at the community level and that community preferences which

might emerge from deliberative processes advocated by such a list could enhance a system of priority setting by programme budgeting and marginal analysis. Mooney accepts that the maximisation of health does not provide a comprehensive account of what matters in health-care rationing but focuses instead on values, and implicitly on the shared values of sub-groups within the population. Mooney's work involving Australian Aboriginals is undoubtedly significant for our understanding of ways in which ethnic minorities can be included, though it leaves open the theoretical question of how sub-groups are specified, particularly in cultures where identity springs from a variety of criteria.

This collection concludes with a methodologically focussed paper by Jeff Richardson and John McKie in which the authors argue for the value of empirical ethics.² Their theme concerns what some might describe as the crowding out of empirical work by the historical rise of a kind of theory that develops in relative isolation from an engagement with empirical facts. In surveying some of the international evidence that does exist, Richardson and McKie suggest that evidence concerning severity, the rule of rescue, differences in capacity to benefit from treatment, age group, cost and a variety of other values do impact on attitudes to health-care rationing even if not in the way that benefit-cost analysis prescribes. This evidence, it is argued, helps make a case for an iterative approach to the development of ethical guidelines for priority setting. Without claiming to provide answers, these researchers are frank about the diversity of responses that may follow, both as a result of the methods used as well as the different ideological positions that people might take. It is difficult to disagree with the view that a more explicitly social choice theoretic approach, open to empirical evidence, would be scientifically helpful, a thread that runs throughout this collection.

In conclusion, we hope that the papers will make contributions to debates about the shape of health-care rationing processes, and also that they will be of value to those interested in the application and development of Sen's capabilities perspective in a variety of social science and health research fields.

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² See Miller (1992) and Gaertner (1994) for more on the role of empirical ethics and its complementarity with a capability based approach to welfare economics.

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Paul Anand^{a,*}

^a *Economics Department, The Open University, Milton Keynes MK7 6AA, UK*
E-mail address: p.anand@open.ac.uk

Paul Dolan^b

^b *ScHARR, University of Sheffield, Regent's Court, 30 Regent Street, Sheffield S1 4DA, UK*
E-mail address: p.dolan@sheffield.ac.uk

*Corresponding author. Tel.: +44-1908-654553; fax: +44-1908-654488.