HEALTH CAPABILITY: AN ATTEMPT TO CLARIFY AN ALTERNATIVE APPROACH FOR HEALTH SOCIOLOGY

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Abstract. Understanding health is a major issue for humanities and social sciences. As its traditional definition dates back to 1948, there is a need to rethink this concept. The capability approach questions what people are actually able to do and be given their real opportunities. In the domain of health, researchers in health ethics and health economics have begun to take a capability approach to study the capacity to make informed choices, or to find broader indicators for the economic evaluation of health interventions. Finally, the recent « Health Capability Paradigm » (Ruger 2010) draws on the philosophical, political and economic theories which have attempted to uncover the dimensions which underlie the capability to achieve a state of optimal health. Paradoxically, despite the undeniable importance of this concept, no research has enabled its operationalization.

Our aims are to present the capability approach by describing its general principles, describe a selection of studies based on this approach in the domain of health, analyse Ruger's Health Capability Paradigm and suggest possible research perspectives to this paradigm.

Keywords: Capability approach, health, quality of life.

Résumé

Comprendre la santé est un enjeu majeur pour les sciences humaines et sociales. La définition traditionnellement retenue pour la définir remontant à 1948, il est devenu nécessaire de repenser ce concept. L'approche par la capabilité interroge ce que les gens sont réellement en mesure de faire et d'être, étant données les opportunités réellement à leur disposition. Dans le domaine de la santé, des chercheurs en éthique et en économie ont adopté cette approche pour évaluer la capacité de faire des choix éclairés et proposer des indicateurs plus larges pour évaluer les interventions. Enfin, le récent « paradigme de la capabilité de santé » (Ruger, 2010) a tenté de mettre au jour les dimensions qui sous-tendent la capacité à atteindre un état de santé optimal. Paradoxalement, et ceci malgré l'importance indéniable de ce concept, aucune étude n'a encore proposé son opérationnalisation.

Nos objectifs ont été de présenter l'approche par la capabilité en décrivant ses principes généraux, décrire une sélection d'études qui se sont appuyées sur cette approche dans le domaine de la santé, analyser le paradigme de Ruger et proposer les perspectives de recherche qu'offre ce paradigme.

Mots-clés: Approche par la capabilité, santé, qualité de vie.

Rezumat

Înţelegerea sănătăţii este o provocare majoră pentru ştiinţe sociale şi umaniste. Definiția utilizată în mod tradiţional pentru a o defini datează din 1948 și a devenit necesar să

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regândim conceptul. Abordarea prin capabilitate pleacă de la ceea ce sunt oamenii capabili să facă şi să fie realmente fiind date oportunităţile lor reale. În domeniul sănătăţii, cercetători în etică şi economie au adoptat această abordare pentru a evalua capacitatea de a face alegeri adecvate și a propune indicatori mai ampli pentru a evalua intervenţiile. Recenta " paradigmă a capabilității sănătății" (Ruger, 2010) a încercat să actualizeze dimensiunile care stau la baza capacității de a atinge o stare de sănătate optimă. Paradoxal, în ciuda incontestabilei importanţe a acestui concept, nici un studiu nu a propus operaţionalizarea lui. Obiectivul nostru este acela de a prezenta abordarea prin capabilitate, de a prezenta o selecţie de studii care s-au bazat pe această abordare în domeniul sănătăţii, de a analiza paradigma lui Ruger şi de a arăta oportunităţile de cercetare oferite de această paradigmă.

Cuvinte cheie: Abordare prin capabilitate, sănătate, calitatea vieţii.

1. Introduction

Health has become a central concern in humanities and social sciences. Theoretical models of health integrate and emphasize the interactions between biological, psychological, social and environmental factors, such as the bio-psychosocial model (Engel 1977), the ecological model (Bronfenbrenner 1979) or the eco-social approach (Krieger 2011) to health. Each model seeks to best represent the diversity of the determinants of health and they sometimes include a temporal perspective that endeavors to highlight the dynamic aspect of health.

An approach which has attempted to further expand the scope of the study of the capability approach. This approach aims to evaluate the possibility of achieving optimal health. Based on moral values, the capability approach is a major contribution to the understanding of social phenomena related to health. Therefore, the variable in question becomes not health, but the ability to achieve one's own optimal health. This alternative way of viewing the quality of life offers new perspectives in sociology.

Even though the capability approach is already used in the disciplines of Humanities and Social sciences such as philosophy (Nussbaum 2011), economics (Kuklys and Robeyns 2005), and political science (Alkire 2005), it is still little known in the fields of sociology and psychology. However, its use by scholars in the design and the measure of the quality of life, has no doubt broadened our understanding of the development of human behaviour.

Our purpose is to: Present the capability approach by describing its general principles, describe a selection of studies based on this approach in the field of health, analyzing Ruger's (2010) Health Capability Paradigm and finally, suggest possible applications of this paradigm.

2. The capability approach

The capability approach is a way to perceive quality of life and human dignity. It was developed by Amartya Sen, an economist and philosopher, as an alternative

perspective to the economic models of the 1980s which were based on development indicators that were either financial or satisfaction based.

Sen aimed to give back moral values to the economic approaches prevailing at that time (Sen 1993).The approach based on resources measured the development of a country by its wealth, whereas utilitarianism consisted of improving the satisfaction of inhabitants. Rather than focusing on economic or perceptual indicators, Sen proposed to measure human development, by maximising human capabilities. Thus, capability is defined as what people can actually do or are, according to their actual opportunities. In 1998, Sen received the Nobel Prize in Economics for his work on famine and the fundamental mechanisms of poverty among others.

3. General principles

The capability approach states that every human being has the right to live a worthy life, and that it is the duty of the society to ensure that everyone has at least the threshold of dignity. This involves the respect of human rights, and safeguarding of equal opportunity which gives the individual the freedom to act or not to act in a particular way; in other words, to live the life they have chosen to live. The capability of a person can therefore be defined by his or her ability to implement their freedoms to live a life they have reasons to value (Sen 1992).

A person’s capability is composed of four parts: well-being freedom, well-being achievement, agency freedom, and agency achievement (Sen 1992). Thus, assessing a person’s capability includes an evaluation of his or her current way of functioning, and to analyse his or her freedom to achieve this status. Does his or her lifestyle result from an informed choice or is it an adaptation to his or her environment? Two concrete examples will help understand these notions. The first one is widely used to illustrate the capability approach.

3.1. Examples

Example 1. Food restriction

If we consider the situation of two people that hardly eat. One of them is a victim of poverty and therefore cannot feed adequately. The other one has access to food but is fasting, as he or she has learned that this practice, carried out under the supervision of a specialist, could be beneficial to the health.

The observable functioning in these two people is the same, in the sense that they both know the absence of food. What makes them different is the degree of freedom in which they have to adopt this behaviour. For the first person, the gap between his or her current situation and their desired situation is high. In contrast, the second person has chosen to underfeed herself; it is a preference that she has implemented for a short time. His or her condition also was to make informed choices about their feeding mode.

Example 2. Choice of lifestyle
Two people from the same village, one spends his free time on cultural activities such as being part of a choir, participating in painting workshop and a poetry group. The other prefers to spend his free time gardening, watching television and entertaining friends and family at home. In terms of functioning mode, these two people differ in a visible way: the first one goes out regularly and is involved in training groups and cultivates his taste for culture. The second prefers to spend his time at home and, after being involved in various cultural activities, decided not to further pursue this goal. Despite the apparent differences in the observable lifestyles of these two people, they have a degree of capability considered equal, since they obtained the same opportunities, but their differences are the result of personal choice.

The strength of the capability approach lies in not imposing an idea of what constitutes a good life and giving importance to freedom of choice (Alkire 2005). As our second example shows, the capability approach does not impose any lifestyle as being the only one worth living. On the contrary, after ensur in g that each person can recognise and benefit from their fundamental capabilities, it is the approach encourages people to choose their own lifestyle, according to their own preferences and individual differences.

4. The capability approach in the domain of health

In theory, any capability can be developed. In practice, certain capabilities have attracted more attention than others. For example, according to Sen and Nussbaum's point of view, health is an essential area of human development (Nussbaum 2011).

The capability to be healthy is considered a meta-capability (Venkatapuram 2011) which results from a combination of several 'simple' capabilities, like feeding oneself or exercising (Sen 1993). For example, to be healthy, we must above all else be able to nourish ourselves properly, have access to validity proven health care, work under favourable conditions, live in an unpolluted environment, etc. Health functioning compares results from interactions between different healthy behaviours and certain predispositions. Health agency is the freedom to achieve health goals that a person has reason to assign value to and to be a player in his or her own health. Conditions that determine the capability to be healthy are biological, epidemiological, social, environmental and political (Fins 2012).
A number of studies used the capability approach to analyse people's health issues. These include health ethics, health economics and health policy. In the following part, a selection of works will be presented.

Among other broad concepts such as lifestyle and the value attached to it, the works that rely on the capability approach in the field of health, have permitted the broadening of the traditional interpretations of health economics and ethics of

public health and the creation of instruments for measuring capability. The latter has been possible since this approach has gone beyond certain disadvantages associated with instruments of measurement commonly used in the social sciences.

5. Capability and human rights

In health ethics, some researchers have relied on the capability approach to study the extent to which human rights are respected, for example in decisions taken at end of life (Anand 2005) and claiming the right to HIV/AIDS prevention (Meier et al. 2012). Other authors have questioned the freedom to make informed health choices. For example, how our environment fosters or impedes healthy eating habits or the level of awareness of drug users (Mulvaney-Day et al. 2012; Womack 2013). These studies have demonstrated that the conditions in which people make healthy choices are often unfavourable and the same studies have highlighted the need to improve these conditions. Particularly conditions related to environmental barriers such as the influence of social norms, quality of received information or weaknesses of health systems. However, barriers from personal factors have not been expanded upon.

Implementing the capability approach consists of facilitating ways for people in vulnerable situations (Guinchard and Petit 2011)to find regain, or claim their rights concerning their health and dignity. For example, in highly structured and hierarchical hospital systems, the capability approach postulates that institutional functioning can be improved through individual contributions. Society must protect people and on the other hand, society has to make them aware of their ability to protect themselves. This gives them the opportunity to develop themselves these abilities if they choose to.

6. Capability and health economics

Health economists have also been interested in using the capability approach in the economic evaluation of complex health interventions. Their aim is to change the research methods used to assess the efficacy of an intervention. One of the classical instruments used as a benchmark in the evaluation of interventions (Wonderling et al. 2011) is the EQ-5D (Brooks 1996). The EQ-5D measures quality of life in five dimensions: mobility, self-care, usual activities, pain/discomfort and anxiety/ depression. Its validity has been proved, but it has been criticized for two main reasons. First, for not including the social dimension of health as defined by World Health Organization in 1948. Second, for assuming that effective interventions (using health related quality of life instruments) are supposed to improve one of the EQ-5D domains, which narrows the spectrum of the evaluation. However, the benefits of a complex intervention cannot be reduced to an increase of health related quality of life. Most interventions show that their results consist of raising

awareness, improving knowledge, motivation or self-efficacy. These aspects are not measurable through an indicator such as the EQ-5D.

Thus, some researchers, mainly based in the United Kingdom, have sought to create instruments measuring people's capabilities. The first team, led by Paul Anand, has discerned what evokes capability among the items of an existing questionnaire (Anand et al. 2005). Items from the national UK survey were selected to construct an18 items-questionnaire of capability (Anand et al. 2009; Lorgelly et al. 2008). Dimensions of capability which were associated with life satisfaction were among others, having the opportunity to be housed in a decent place, having the capacity to express one's emotions, to not be pressured, to plan one's life, and to feel useful.

The second team, led by Joanna Coast, operationalized capability in the context of decision making in health care. First, leading a qualitative study, the researchers identified five particularly important areas in the life of elderly people: their possibilities of attachment, autonomy, joy, stability and security. An item was created for each area, which led to a five-item questionnaire named ICECAP-O (for Investigating Choice Experiments for the preferences of older people - Capability measure for Old people) (Coast et al., 2008). This instrument measures the capability of the elderly to behave and act in accordance with their values. A second instrument was designed to measure the capability of adults in general. The ICECAP-A (A for Adults) includes five areas of capability (and therefore five items): stability, commitment, independence, success and joy (Al-Janabi et al. 2012). Moreover, an analysis of exploratory intervie wsof people with chronic pain highlighted the aspects of life they value. This led to the creation of a preliminary questionnaire of capability representing nine areas: feeling respected, enjoying social interaction, fulfilling the role of parent or grandparent, staying active mentally and physically, having a positive individual identity and being independent, being involved in a romantic relationship, feeling well physically and mentally and gaining pleasure from life (Kinghorn 2010). The first analyses of questionnaire responses revealed that the most salient capabilities in terms of quality of life were the ability to feel well physically and mentally and the opportunity to be active mentally and physically, have social relationships and control over one's life. To our knowledge, these questionnaires are not yet reflected in the literature.

7. The controversy of operationalising capability

Despite the fact that this approach has already attracted and continues to attract a growing number of researchers in health economics, the operationalization of capability also raises philosophical debates about the relevance to measure it or not

Those who tried to operationalise capability have received criticism from their peers (Al-Janabi et al. 2013). According to critics, capability cannot be measured

directly since it consists an area of freedom between an effective and an optimal functioning. In addition, assessing capability only through responses to self-reported questionnaires gives only a subjective view, which is not consistent with the approach which should combine subjective and objective assessments (Cookson 2005).

8. The Health Capability Paradigm (Ruger 2010)

In 2010, Jennifer Prah Ruger, a researcher in the domains of medical ethics and health policy, developed the health capability paradigm which is based on both the capability approach and the ethical principle of human flourishing(Ruger 2010a).

In this paradigm, health capability is the ability to be effective in achieving an optimal health (Ruger 2010b). It is defined by health and the capacity to make informed health choices. The current health status (health functioning) is seen as the result of the interaction between different health behaviours and certain predispositions. Health agency is the freedom to achieve health goals that one has reason to value and to be an active player in one's own health.

The conceptual model shows that health capability results from the combination of social and environmental conditions, health policies as well as biological and psychological characteristics (Ruger 2010b). According to Ruger, the health capability paradigm allows us to find a balance between paternalism (where choices are made by professionals) and autonomy (where health choice sareguided by one's own motivations. She thus claims that her paradigm is the theory of a right to health.

8.1. A conceptualization of health capability

Ruger began to operationalize health capability by offering a list of concepts and dimensions that together make up its profile (Ruger 2010b). Fifteen internal and external dimensions, subdivided into 49 categories compose health capability and consist of factors which when combined, represent the health capability of a person (*see Table 1*).

Internal dimensions. The internal dimensions of health capability cover objective data such as certain biomarkers, and subjective concepts such as "values", "attitude", "skills" and "beliefs". One's health capabilities partly a function of the psychological mechanisms at work. Thus, an optimistic person, who values to his or her health, has positive expectations towards health behaviours and believes in his or her abilities to cope with a given situation, has a higher health capability that a person who has opposing traits. The internal dimensions follow a logical progression ranging from knowledge, beliefs, attitudes, skills, to health behaviours. These dimensions include concepts found in traditional models of health behaviour prediction (Godin 2012), and also include life skills, as described

by the division of Mental health of the World health Organization (Program on mental health. World Health Organization 1994, p. 14). The correspondences between the concepts found in the internal dimensions of the health capability profile and those used in other theories (prediction of health behaviour and life skills) are presented in tables 2 and 3.

External dimensions. Situations and external conditions that promote or hinder health and how to preserve health consist the other half of the profile. They cover the micro, macro, political and environmental conditions. Some dimensions can be self-measured, e.g. social support, physical conditions, interactions with health services, whereas others could be expressed by external parties (e.g. social norms, status of the public health system of a country, etc.).

Table 1. *Dimensions composing the health capability profile* (from Ruger, 2010b)

Internal dimensions	**External dimensions**
Health status and health functioning Health knowledge Health-seeking skills and beliefs, self-efficacy Health values and goals Self-governance and self-management and perceived self-governance and management to achieve health outcomes Effective health decision-making Motivation to achieve desirable health outcomes: intrinsic or extrinsic Positive expectations about achieving health outcomes: optimistic or pessimistic	Social norms Social Networks and social capital for achieving health outcomes Group membership influences to supplement or counterbalance social norms and social assistance in other social contexts Material circumstances Perceived economic, political, and social security Utilization and access to health services Enabling public health and health care systems

8.2. Usefulness of the paradigm

The capability approach is based on moral values and allows to give importance to freedom and human rights. Ruger's paradigm attempts to clarify the components of health capability and present several points of interest for humanities and social sciences. First, its dimensions are close to the determinants of health, which highlights that health capability is larger than health. Secondly, it gathers concepts stemming from various disciplines and thus encourages interdisciplinary research. Third, it attaches importance to the internal dimensions of the health capability as well as to the external conditions, while other works in the field place particular emphasis on the external conditions needed to promote capability of human beings. Thus, it allows not to limit our understanding of the role of each factor to only external conditions.

Table 2.Correspondences between the internal dimensions of the health capability profile and concepts found in health behaviour prediction and change models

Internal dimensions of the health capability profile	Models of health behaviours prediction and behaviour change								
	HBM[a]	TPB[b]	TIB[c]	SCT[d]	OE[e]	TM[f]	TSD[g]	MAP[h]	MHAP[i]
Health status and health functioning									
1. Measures of self-reported health functioning	x				x				
2. Measures of health conditions, risk factors									
Health knowledge									
1. Knowledge of one's own health and health conditions									
2. General knowledge of health and disease, preventive measures to protect health, and risk factors for poor health									
3. Knowledge of costs and benefits of health behaviours, lifestyles, exposures									
4. Knowledge of how to acquire health information and knowledge									
Health-seeking skills and beliefs, self-efficacy		x		x					x
Health values and goals									
1. Value of health									
2. Value of health-related goals									
3. Value of lifestyle choices and behaviours									
4. Ability to recognize and counter damaging social norms									
Self-governance, self-management, perceived self-governance and management to achieve health outcomes									
1. Self-management and self-regulation skills and expectations									
2. Ability to manage personal and professional situations: ability to handle external pressures									
3. Ability to make the connection between cause and effect with regard to personal behaviour and health outcomes; personal responsibility									
4. Ability to draw on networks of social groups									
5. Vision, direction, planning, strategy, and ability to make positive health choices						x		x	x
Effective health decision-making									
1. Ability to effectively use both knowledge and resources to prevent onset or exacerbation of disease or prevent death									
2. Ability to weigh the short-term and long-term costs and benefits of health behaviours and actions	x								
3. Ability to identify health problems and pursue effective prevention and treatment									
4. Ability to make healthy choices under various environmental constraints									
Motivation to achieve desirable health outcomes: intrinsic or extrinsic							x	x	
Positive expectations about achieving health outcomes: optimistic or pessimistic				x					x

[a] Health BeliefModel (Rosenstock 1974); [b] Theory of Planned Behaviour(Ajzen 1991) ; [c] Theoryof Interpersonal Behaviours(Triandis 1979); [d] SocialCognitive Theory(Bandura 2001); [e] Optimal Experience (Csikszentmihalyi 1992) ; [f] Transtheoretical Model (Prochaska and DiClemente 1992) ; [g] Theoryof Self-Determination (Ryan and Deci 2000); [h] Model of Action Phases (Achtziger and Gollwitzer 2008); [I] Model ofHealthAction Processes (Schwarzer 1992)

Table 3. Correspondences between the internal dimensions of the health capability profile and life skills (Program on mental health. World Health Organization 1994)

Internal dimensions of the health capability profile	**Life skills (Program on mental health. World Health Organization 1994)**									
	Problem solving	Decision making	Creative thinking	Critical thinking	Communic-ation	Interpersonal relationships	Self-Awareness	Empathy	Stress coping	Emotional coping
Self-governance, self-management, perceived self-governance and management to achieve health outcomes										
1. Ability to acquire skills and apply them under changing circumstances			**x**							
2. Ability to recognize and counter damaging social norms				**x**						
3. Self-management and self-regulation skills and expectations										
4. Ability to manage personal and professional situations: ability to handle external pressures	**x**								**x**	**x**
5. Ability to make the connection between cause and effect with regard to personal behaviour and health outcomes; personal responsibility										
6. Ability to draw on networks of social groups					**x**					
Effective health decision-making										
1. Ability to effectively use both knowledge and resources to prevent onset or exacerbation of disease or prevent death	**x**	**x**								
2. Ability to identify health problems and pursue effective prevention and treatment	**x**	**x**								
3. Ability to make healthy choices under various environmental constraints	**x**	**x**	**x**							

8.3. Applications of Ruger's paradigm

Ruger's ambition is to create an index of health capability. To do this, she asserted that it was the necessity to determine the relationship between each dimension and its respective contribution. Her project is still in a state of reflection, and she plans to create a battery of questions to measure health capability. To date and to our knowledge, no study has yet used this paradigm and therefore no measurement instrument is currently documented in the literature.

9. Research perspectives

The health capability paradigm draws on the philosophical, political and economic theories which have attempted to uncover the dimensions which underlie the capability to achieve a state of optimal health. Paradoxically, despite the undeniable importance of this concept, no research has enabled its operationalization. Firstly, a health capability instrument would allow to assess people's specific needs and priorities of health capability dimensions to be strengthened, which would allow their referral to better suited education and support programs. Secondly, such a scale would evaluate the performance of the programs' content. Such a project has been undertaken concerning family caregivers (Bucki 2014). This thesis developed a procedure to operationalize eight dimensions of the health capability profile, resulting in a 20-item questionnaire. The dimensions that contributed the most to health capability regrouped physical health, family support and financial disposition. The results have highlighted innovative and novel tracks for improving family caregivers' health capability, enhancing both their autonomy and their need to be supported in maintaining their skills towards their health. In addition, a thematic content analysis of the verbatim corresponding to the internal dimensions of health capability led to the creation of 77 additional items measuring, in addition to the originally formulated dimensions, life skills and coping styles. The general structure of Ruger's paradigm was retained but changes were needed. Future studies would benefit from developing instruments of health capability which would address two major purposes once their clinical validity has been verified by clinicians, and their psychometric validity completed.

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