Health capabilities and the dignity of the individual

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"Without health nothing is of any use, not money nor anything else." (Democritus)

1 Introduction

To address how health care contributes to human flourishing, we discuss the normative objectives of care systems. But where do the normative objectives of care systems come from? How do care systems come to have certain normative objectives and not others? Suppose we take care systems to be networks of institutions built up around the interaction of people in and across the social groups involved with and concerned about patient-clinician relationships. Here, then, I frame our discussion of the normative objectives of care systems in terms of how this social interaction determines the fundamental objectives of care. I argue that the normative objectives of care emerge ground-up, as it were, from the direct contact and interaction between people who are immediately concerned about the nature and provision of care. These objectives then take on additional form in the wider interaction between social groups that produces the health and medical care institutions that make up entire care systems. At this level, the normative objectives of care get formulated in broad cross-institutional terms that guide society's general policies and values regarding care. That is the subject of another discussion. In effect, then, this paper concerns the micro basis for normative objectives in health care systems, not their macro basis.

When we think of individuals as socially embedded, we can argue that this social embedding generates collective intentions and shared expectations about care between people. Interaction between embedded individuals then produces "moral communities" in the sense of Hodgson (2013), whose values pervade the entire space of institutions and care systems. What I argue here, then, is that only certain specific types of values and normative objectives regarding care arise out of the interaction between socially embedded individuals. Mainstream health economics essentially fails to recognize the existence of these types of values and normative objectives, and consequently operates with a deficient understanding of care, because it operates with un-embedded, socially isolated individuals, who by nature do not develop collective intentions and shared expectations about care. Thus, the view here is that understanding the normative foundations of care depends on understanding the social connections between people who interact closely with one another in the provision of care.

What this perspective requires, I argue, is that we think about care in terms of capabilities, the well-being concept developed especially by economics Nobel laureate Amartya Sen (cf. Sen, 1993, 1999) and the philosopher Martha Nussbaum (Nussbaum 2011).[1] In contrast to mainstream economics' utility concept of well-being formulated in terms of the preferences of un-embedded, socially isolated individuals, for Sen and Nussbaum capabilities have an inescapably social character because individuals' capabilities are always exercised in social settings in interaction with others. This applies to all the capabilities for the many different things that people can be and do (referred to as their functionings), and it particularly applies to the capability for having good health, which depends not only on the social interaction in the patient-clinician relationship but also ultimately on all the other social relationships connected to that relationship. Indeed, in this regard, the capability for having and being in good health is, as the epigraph above from Democritus says, a central human capability. Because the capability for good health is so important to having so many other human capabilities, its provision is arguably more deeply and widely embedded in the social relationships that make up life in moral

[1] See Crocker (2008) and Robeyns (2011) for a general review of the capability approach.

communities than any other capability, as reflected in the array of health and medical institutions built up around care as well as the development of whole health care systems.

In what follows, in section 2 I first explain the nature of the health capability, and then explain how people's different health capabilities are socially embedded in care relationships. I then show in section 3 how this social embeddedness promotes only certain specific types of values and normative objectives regarding care – ones that are different from those promoted by mainstream health economics. Finally in section 4, I discuss what the nature of the person is who is the focus of care in socially embedded in care relationships. The view is that the specific types of values and normative objectives regarding care that I identify imply a particular normative conception of the person, namely, a person intrinsically worthy of being treated with dignity. This conception of the person is missing from standard health economics. I argue that the conception of the person as intrinsically worth of being treated with dignity underlies the argument for regarding equity in health a foundational value in the design social policies for the development of health care systems.

2 Health capabilities and their social embeddedness in care relationships

Why capabilities rather than a utility-based measure of health, such as quality-adjusted life year (QALY) or disability-adjusted life year (DALY) employed by most health economists using cost-utility analysis? One of the reasons is it important to think of health in terms of capabilities rather than utility measures of health is that this creates a distinction between health achievements and the ability people have to pursue good health. Health achievements are an outcome measure of health care, but when we also include the ability people have to pursue good health in our thinking, we include people acting as agents of their health in our assessment of their well-being. There are a number of reasons why one should adopt this larger perspective. First, the risk of thinking of health only in terms of health achievements is that doing so tends to put the emphasis on average health needs and misses the heterogeneity of health needs across people. The latter comes out when we emphasize how individuals act as agents of their own health.

Second, when we focus only on health achievements, we miss the many relevant aspects of health that depend on what people do. Health is not just a state person is in, but involves a whole variety of activities and practices in which the person's health undergoes continual management by themselves in collaboration with clinicians, family, and community. Third, when we think only in terms of health outcomes, we tend to think of health in terms of the biomedical paradigm. Health then becomes a matter of disease diagnosis and epidemiology, not a care relationship, and this risks making health care a matter of a paternalistic delivery of care services.

Jennifer Ruger's *Health and Social Justice* characterizes health capability as "a person's ability to be healthy" (2010: 3). The emphasis on ability as a potentiality is important. Among other things, people's actual health achievements reflect their access to care, which may be quite uneven across individuals and social groups, and thus often fall short of what they could achieve were health resources more abundant or differently distributed. As Sen puts it, when I see people not receiving health care, I judge there to be a "lack of opportunity … because of inadequate social arrangements" (Sen, 2004: 23). The other side of the care that people do receive, we might then say, is the care they do not receive. Ruger captures this by framing the health capability concept in opportunity terms as the idea of a health capability gap. I will say more about this involves below, but here emphasize that methodologically it means we need to think of the provision of health as simultaneously a practical and a normative concern. In particular, how we characterize and describe care arises directly out of our normative objectives regarding what care people should achieve.

Contrast this with the utility-based QALY approach which first records in a purely descriptive way what people prefer regarding different health states as a kind of neutral data, and then goes on to introduce normative criteria to determine the distribution of care, such as in the 'fair innings' approach which attaches 'equity weights' to sets of QALYs to achieve a normative objective independent of the nature of people's preferences (Williams, 1998; Culyer and Wagstaff, 1993). The problem with this is that normative criteria introduced after the fact have a certain degree of arbitrariness about them. Why not other criteria? In the capability approach, however, the emphasis on opportunity as

a measure of health directs us immediately to what people believe good health involves and the kind of life they wish to live so that our normative criteria are implicit in our understanding of care from the outset.

Ruger thinks of care in terms of human flourishing or as the idea of people being able to develop their capabilities across the many desirable dimensions of life – physical, psychological, and social – through their own agency and in collaboration with others. This shows us that a reason the health capability is centrally important to life is because one cannot flourish without it. The human flourishing idea also underlies the social nature of health, because one cannot successfully pursue it and flourish except in interaction with others. Ruger thus regards health capability as intrinsically valuable. At the same time, she recognizes that the many different kinds of health capabilities are not all equally important. Following Sen, she accordingly distinguishes between health capabilities regarded as 'central' and health capabilities regarded as non-central or 'secondary' with the difference between them being their importance for human flourishing (Ibid: 4). Sen regards 'basic capabilities (Sen, 1980) as "crucially important capabilities dealing with what have come to be known as 'basic needs'" (1993: 40). For example, for him 'basic' health capabilities are being able to avoid premature mortality and being adequately nourished, whereas a 'secondary' health capability is being able to enjoy recreational activities. Accordingly, 'basic' health capabilities are essentially prerequisites for 'secondary' health capabilities, and should thus receive priority in advancing people's overall health capability.

I interpret this to mean that providing people 'basic' health capabilities constitutes a common ground of understanding for people across the many different overlapping, interconnected care relationships that make up health care systems. That is, across all these care relationships, people share an intention regarding what the 'basic' health capabilities are that people should all have. In virtue of their being, 'basic' they are seen as health capabilities that all people ought to equally enjoy, and are consequently ordinarily referred to as what 'we' ought to provide to everyone. That is, inherent in the idea, for example, of being able to avoid premature mortality and being adequately

nourished is the idea that any person should have these capabilities and any shortfall regarding them has priority in the delivery of health care.

Matters are clearly more complicated when we turn from 'basic' to non-central or 'secondary' health capabilities. When we focus on needs, people broadly share the same intentions about the importance of care irrespective of their own individual circumstances. When we focus on non-central health capabilities, people's shared intentions about them form differently across people rather than in the same way for everyone – in effect more 'locally' in relation to the specifics of the care relationships involved – because people have such different health care goals when we go beyond needs. 'Basic' capabilities, actually, are rather exceptional among health capabilities because with them, unlike so many other health capabilities, individual agency is less important in securing them and the achievement side of health is all-important. When we go beyond needs, then, we need to consider not just what society can achieve for people, but also the ability people themselves can have to act as agents of their health. Of course, the ability people have to pursue good health depends on their collaboration with health providers and health providers' collaboration with their patients. So the agency side of health capabilities is two-sided and in this respect very much a matter of shared intentions. At the same time, because the range of health capability gaps must span the wide range of people's different health goals, there must be a multitude of different ways in which health providers and patients find themselves forming shared intentions about care.

One might consequently suppose that this would make it difficult to make sense of the general nature of people's health capability gaps, and accordingly also make it difficult to say anything very specific about the values and normative objectives of health care beyond the equality of need. This challenge derives from the fact that agency and achievement can vary in their importance across different health capabilities. Sen, however, provides us a framework that allows us to lay out a spectrum of cases according to the different roles that agency and achievement play in contributing to, as he puts it, an individual's advantage. It employs two distinctions regarding how we understand the different dimensions of human advantage. One distinction is between what promotes a person's well-being versus what promotes the person's overall agency goals, or "goals other than

the advancement of his or her well-being" (Sen, 1993: 35). The second distinction is between a person able to actually achieve something versus the person simply having the freedom to pursue the objectives she wants to achieve (*Ibid.*).

In Table 1, I apply Sen's framework to distinguish four different (yet interdependent) ways in which I can understand people's health according to the relative importance played by agency and achievement: (1) well-being achievement, (2) agency achievement, (3) well-being freedom, and (4) agency freedom. I explain and illustrate each case in terms of characteristic health capabilities.[2] This then provides a spectrum of types of health capability gaps that differ not only according to the space people have in pursuing good health, but also according to how shared intentions between health providers and patients differ in each the case. This is particularly important to the discussion in section 3 of the different normative objectives people have regarding care, since there I argue that the different ways in which people are socially embedded in care relationships – the source of their shared intentions – determines the basis for their normative understanding of care, where among other things this includes their views of responsibilities and entitlements of providers and patients in care relationships.

[Table 1 here]

In what follows, I discuss each case with examples of health capabilities. I start with the need case in which achievement is foremost – well-being achievement – and move last to the case in which agency is paramount – agency freedom. I address well-being freedom ahead of agency achievement to emphasize an important difference in who the 'providers'

[2] Strictly speaking, Sen associates Well-being achievement and agency achievement with what he terms functionings, the actual being in a state or the doing of something, rather than as a capability, the ability to be in a given health state. Since he also broadly sees capabilities as freedoms, I will treat these cases as health capabilities, understood as freedoms people have to achieve certain health states.

are that bears on the shared intentions involved. In each case I explain the form of shared intention involved. Table 2 summarizes this discussion.

[Table 2 here]

Well-being achievement is the domain of 'basic' health capabilities or needs regarding health care which all people should have irrespective of their individual circumstances. Sen's examples of being able to avoid premature mortality and being adequately nourished are generic examples, but it is not difficult to identify more specific ones. Indeed, when one emphasizes being in a state of need, and places less weight on care recipients' agency in promoting these capabilities, prenatal and neonatal care come quickly to mind. Children's vaccinations and primary health care are another example. Agency is not irrelevant because people must also take steps themselves to secure these health achievements. But that these health capabilities involve needs puts important weight on what society does in ensuring that people achieve good health in this respect. Regarding shared intentions, I thus say that people generally share the same intentions about care in this case. That is, in regard to 'basic' health capability gaps the specific circumstances of care and the particular individuals involved do not enter into our assessments of when and where 'we' believe health capability gaps exist and ought to be addressed.

In the case of *well-being freedom*, what the person freely does in the pursuit of good health becomes more important. The actual achievement of well-being is still quite central to a life of human flourishing, because being in a state of good health underlies having so many other capabilities. But in this case the freedom people have to pursue good health influences the extent to which they achieve it and can flourish in life. Consider the example of chronic hypertension. Because this condition is often a reflection of other possible health conditions that can put the individual at risk for hypertension (diabetes,

a family history of cardiovascular disease, exposure to environmental contaminants, etc.), the person's overall health well-being is directly involved. At the same time, because people can influence the extent to which they suffer from hypertension (through such things as tobacco use, lack of exercise, poor diet, etc.), and can also influence the extent to which they mitigate hypertension, clearly their freedom plays an important role in determining the state of their health. The freedom aspect of the well-being freedom health capability also tells us something about the 'local' nature of shared intentions between health providers and patients it produces. In order to embark on a course of care, the provider and patient must agree on what the health strategies they agree to adopt. The patient must freely adopt these strategies, but the provider needs to help design these strategies according to what they patient can embrace. This might require a set of repeated efforts on their parts in which they work to discover their shared intention regarding the patient's health. Thus the freedom aspect of this capability extends to both.

Sen's *agency achievement* case addresses goals people want to achieve that are distinct from well-being as a goal (though they can be related). One such goal is personal autonomy or the ability to be independent, to do various things on one's own, and to not always depend on others, whether or not this contributes to improved states of well-being.[3] An example of a personal autonomy health capability is social access for disabled persons, whatever their form of disability. In general, disability limits what the disabled can do compared to others, and thus limits their personal autonomy. According to the World Health Organization (2014) about fifteen percent of the world's population suffers from sort of disability that limits their personal autonomy and social access. Achieving access to places of employment, health care services, commercial activity, transportation services, entertainment venues, etc. can improve disabled individuals' well-being, but it is also valuable to them whether or not it does. Having personal autonomy, then, is one example of an agency achievement type of health capability.

[3] Other agency goal capabilities are social interaction, involvement in social causes, and pursuing one's own vocation. What is common to these non-well-being goals is being active in something or being engaged in an activity. To be able to be active at something is an achievement in its own right. If the activity also produces a state of Well-being, then the activity is additionally valued for Well-being reasons.

Needless to say, however, this type of health capability is different from what many people regard as health capabilities, seen as medically linking health providers and patients. Indeed, the 'providers' in this case include people in public health programs who work to design access for the disabled, those who pass and enforce laws requiring it, and those who take it upon themselves to increase access in whatever ways possible to prevent discrimination against the disabled. This is case is similar in some respects to the well-being achievement case, since many people who are not classified as health professionals can be involved in securing people's needs. I nonetheless distinguish this case as involving a lower level of generality across shared intentions between 'providers' and those who benefit. In the well-being achievement case, all people should have all their basic needs fulfilled, but in the case of agency achievement differences in people's agency or personal autonomy means quite different things regarding what health involves according to the form of disability involved. Thus I treat this as a case of different, overlapping shared intentions regarding improving access for the disabled.

Agency freedom, Sen's fourth case, is applied to health capabilities in which achievement is framed by agency, and the freedom to pursue these capabilities is not a means to other goals but is valued as a goal purely for itself. For Sen, this involves the concept of a person "who acts and brings about change, and whose achievements can be judged in terms of her own values and objectives" (1999: 19). A person who exercises agency freedom is consequently one who determines her own values and objectives, which then provide the measure of her achievement. In terms of health capabilities, Sen uses the example of women's control of their own fertility (Ibid: 198ff). Child-bearing and child-raising responsibilities are commonly imposed on women across cultures. Others determine women's goals in this regard for them, and as a result their health can be adversely affected in multiple ways. Conversely, when women are able to control their fertility, access family planning, and act as agents in regard to child-bearing and child-raising in relation to their other goals, their health improves as it comes under their own direction. Their health capability gaps as determined by their own values and objectives are then reduced. This demonstrates that there is an important pure agency aspect to health that depends on how the person herself understands her health. Of course freedom and agency are also involved in well-being freedom and agency achievement, but the

difference here is the link between health and the person's determination of their goals for health.[4]

Clearly, then, health capabilities associated with agency freedom have many dimensions. Indeed, when women determine fertility, they do in connection with their pursuit of many other non-health capabilities, for example in regard to employment and education. Thus their determination of their health objectives is also determination of how good health fits into their lives and thereby a determination of what a life of flourishing is for them. I believe that the ambition to live a life of flourishing is universal among people, though needless to say they commonly disagree about what this entails. This then makes for a rather unusual kind of shared intention since people universally share this intention but also disagree about its object. I accordingly label this kind of shared intention a universal idealized shared intention. Everyone says they share the intention that people be able to pursue good health as makes sense in their lives as an ideal. This characterization may well seem an empty one, and perhaps what some think should instead be said is that there are no shared intentions at all about lives of flourishing, including how this involves health. But I will argue in section 4 that the idealized content of this shared intention is tied to the idea that people are intrinsically worthy of being treated with dignity, and that the key to understanding this agency freedom idea is that others cannot determine what a life of dignity and flourishing means for the individual person. Thus, this universal shared intention, one all people can express using the language of 'we', is necessarily ideal, despite its also providing a foundation for endless disagreement about what a life of flourishing involves.

3 The values of socially embedded health care capabilities

I argued above that an advantage the capability approach has over the positivist utility framework is that it makes the moral values people associate with good health immediate

[4] Sen's example of women's control of their fertility provides an especially clear example of an agency freedom health capability. Other examples in which the person determines their own health objectives are people's choices regarding pain management, integration of physical activity in work-life balance, and end-of-life decision-making.

to our understanding of health. The view is that one cannot really describe and understand what health and health care involve unless one understands what people value in health and in the provision of care. What the discussion of the four different kinds of health capabilities then implies is that there are different moral values associated with each of these four different kinds of health capabilities. My view, moreover, is that since these different kinds of health capabilities are each associated with different forms of shared intentions, the different sorts of moral values associated with each of the four different kinds of health capabilities derive from how shared intentions regarding care are formed in each case. That is, I explain the social basis for moral values in terms of how the interaction between people in the provision of care generates shared values.

Of course people differ significantly both with respect to what moral values they believe are important and with respect to what moral values they believe appropriate in different domains of life. However, when they form shared intentions regarding care, this leads them to settle on shared values they agree underlie that care. In effect, their shared values are the product of the type of social interaction the care relationship involves. This does not mean, of course, that all the other differences regarding what moral values people hold disappear. It only means that when their interaction in health settings causes them to adopt single courses of action regarding the provision of care that differences in their respective sets of moral values become secondary to their moral common ground. In my view this is what makes the care relationship unique among human relationships, whether in the health domain or elsewhere. When people adopt shared intentions regarding care, they commit themselves to finding shared moral ground. What particular shared moral ground they adopt then depends on the nature of the care relationship. In effect, they become socially embedded in the care relationship, and are no longer appropriately described using the utility framework isolated individual idea.

Thus in this section I discuss how each type of health capability and the shared intentions associated with it gives special prominence to a particular moral value. Table 3 summarizes this framework. I consider the four different moral values I distinguish the primary moral values associated with health and health care.

[Table 3 here]

3.1 Well-being achievement and the value of equality

The kinds of health capabilities that correspond to well-being achievement are what Sen sees as basic capabilities or human needs. My examples are prenatal and neonatal care and children's vaccinations. What is characteristic of this kind of health capability is that it is necessary for simple survival, the most elementary form of human flourishing. Consequently, the form of shared intention that people have regarding this kind of health capability is a generally shared intention that all people should achieve such capabilities irrespective of who they are. That is, people differ neither in their attitudes towards people achieving such capabilities nor in regard to everyone having such capabilities. When people say people's basic needs should be met, everyone says this about everyone.

The moral value that follows from generally shared intentions is equality, or the value of treating all people the same on these specific grounds. As a moral value, equality is often applied unevenly across people. People may be treated equally if they have earned a certain entitlement to being treated equally, such as access to employment for people of the same qualifications apart from differences in race and gender. In such cases, individual agency plays a role in determining the scope of equality since the entitlement depends on what the individual has done to acquire the relevant qualifications. However, when we address basic health needs, individual agency is irrelevant, and so the scope of equality is fully general and not conditional upon people's actions. People are equally entitled to basic health capabilities in virtue of being people, and thus the formation of shared intentions regarding providing basic health capabilities is fully general.

3.2 Well-being freedom and the value of *ex ante* responsibility

The health capabilities associated with well-being freedom – my example is chronic hypertension – are capabilities developed directly in the care relationship between providers and patients. I characterize the shared intentions involved as 'local' because they depend on a reciprocal understanding between providers and patients regarding the course of care. Providers need to understand how patients understand their own care and patients need to understand how providers understand the care recommended. When this is achieved, they are able to form shared intentions regarding a course of care that imposes different yet interlocking sets of responsibilities on each. The shared intentions are 'local' in the sense that they are tied directly to the provider-patient relationship rather than include others sets of people.

I characterize the value of responsibility in this case as an *ex ante* responsibility to distinguish it from the value of *ex post* responsibility. One says someone has an *ex post* responsibility when we explain responsibility in terms of a causal chain that can be traced back to an agent responsible for an action (Ballet, Bazin, Dubois, and Mahieu, 2014, pp. 29-30). While this is an important meaning of responsibility, traceability depends on social circumstances, such that it is often difficult to say when circumstances are complex, who and who in what degree bears responsibility for something that happens. In contrast, when one speaks of *ex ante* responsibility one makes responsibility an inherent characteristic of the identity of the individual (Ballet, Bazin, Dubois, and Mahieu, 2014, p. 39). The person sees herself as having a particular set of responsibilities according to who she believes she is. In regard to well-being freedom, then, when the person exercises her freedom to achieve a state of well-being, she does so with an understanding that this is her personal responsibility – whatever the ultimate consequences may be from an *ex post* responsibility perspective. In the care relationship, then, both providers and patients have an *ex ante* responsibility regarding this relationship in virtue of the reciprocal nature of their roles. The shared intentions they form, then, presuppose they see themselves as having these interlocking responsibilities.

3.3 Agency achievement and the value of human rights

The type of health capability associated with agency achievement concerns goals people want to achieve that are distinct from well-being as a goal, such as personal autonomy or the ability to be independent, and to not always depend on others, whether or not this contributes to improved states of well-being. My example for this kind of health capability is social access for disabled persons. The shared intentions involved in this case differ from the sort of 'local' interlocking shared intentions discussed above, because here shared intentions form across a variety of different types of domains, in virtue of the many ways in which the disabled suffer lack of access, rather than in just the provider-patient setting, and because many different kinds of people are involved in determining social access, ranging from building designers to public health officials and of course the disabled themselves. Thus I characterize the shared intention involved in this case as overlapping. Though there are different kinds of people involved and access means different things on account of differences in disability and ways in which it can be limited, nonetheless there all these instances bear a 'family resemblance' to one another (Wittgenstein, 1953) that justifies regarding the shared intentions involved as overlapping.

The moral value people then that place on this type of health capability is the value of respecting human rights. There are of course different kinds of rights, but human rights accrue to people simply in virtue of what it means to be a person. That is, human rights are the "basic moral guarantees that people in all countries and cultures allegedly have simply because they are people" (Nickel, 1992, p. 561). One thing consequently inherent in this idea is the ability to be independent. People lose their status as persons, when they are dependent or confined in ways to which they object. To be a person, that is, one needs to be self-determining according to the standards society sets for people generally. Thus, in a society understood as to be made up of individuals having the status of persons, individual people have a human right to what is required to achieve this status, whether or not it contributes to their well-being. This accordingly applies to disabled individuals in regard to whatever limits their ability to be self-determining.

3.4 Agency freedom and the value of freedom, negative and positive

The type of health capability agency freedom involves being able to determine one's own values and objectives, as well as the measures of their achievement. Agency freedom can be compared to agency achievement in the following way. Whereas agency achievement concerns people determining *which* goals they wish to pursue, agency freedom concerns simply being able to determine one's goals. That is, agency freedom makes freedom a capability. My example to illustrate a health capability of this kind is women's control of their fertility. When one considers what this involves, it becomes clear that there are two dimensions to women's control of their fertility. One is associated with the concept of negative freedom, or a freedom to not be interfered with by others in one's pursuits. As is well known, women are often limited by laws and customs in their decision-making about whether they will have children. The second dimension of this is associated with the concept of positive freedom, or the freedom to take control of one's life and be self-directed (Berlin, 1969). This dimension of freedom is no less important to the capability of controlling one's fertility since a person could be free of external constraints but be unable to make a decision. This is not a matter of simply being ambivalent or undecided. An absence of positive freedom is an absence of being able to be self-directed.

I characterize the shared intention in this case as a universal idealized shared intention. The weight falls on the notion 'idealized.' When we discuss a deep concept such as freedom, in either its negative or positive dimensions, there are so many different ways in which we can describe what having or not having freedom involves, that it is really impossible to catalogue a set of conditions which would allow us to say when a person is unconstrained and self-directed. However, people feel strongly about the concept of freedom, clearly distinguish cases of negative and positive freedom, and accordingly can be said to have an idealized grasp of it. Moreover, people generally share intuitions about freedom in these two dimensions, even when they disagree about examples. Thus, I characterize the shared intention in this case as a universal idealized shared intention. There are indeed many things about which people exhibit this special sort of shared intention, but in my view health is one of the most important, as I believe is evident from the example of women's control of their fertility.

4 The nature of the person as a focus of care in socially embedded in care relationships

The view here, then, is that the types of values and normative objectives regarding care that I have identified above imply a particular normative conception of the person, namely, a person intrinsically worthy of being treated with dignity. In this section, I defend this claim on two levels: first in terms of what thinking in terms of capabilities tells us about the conception of the person, and second in terms of what thinking in terms of the four main normative values discussed above tells us about one's conception of the person. I take this task to be especially important because in my view a fundamental problem with mainstream health economics is that it operates with a normative conception of the person inadequate to a health economics that emphasizes care. Consequently, this section closes by contrasting the mainstream conception and a conception of the person that emphasizes care.

4.1 The capability approach and the dignity of the person

We saw in the last section that Sen's capability framework allows for four different ways in which individuals' development of their capabilities contributes to their personal advantage. If we then take these different kinds of functionings and capabilities as what makes up what a person is, people can be represented as the collections of capabilities that they develop and seek to develop. But how do the different capabilities that people have and seek to acquire add up to give us a single conception of the person or to a cohesive personal identity? Sen has long emphasized that a special characteristic of the person is being able to be a self-scrutinizing agent who judges and deliberates about her opportunities rather than simply react to them based on some set of hard-wired preferences.

> A person is not only an entity that can enjoy one's own consumption, experience, and appreciate one's welfare, and have one's goals, but also an entity that can

> examine one's values and objectives and choose in the light of those values and objectives (Sen, 2002, p. 36).

I suggest, accordingly, that an important dimension of Sen's concept of agency freedom, the capability of being able to reflect on one's goals, is that it functions as a kind of second-order capability, or meta-capability, by which a person to able to not only judge the relative importance all the first-order capabilities she has and seeks, and also how they all fit together in the life she chooses to pursue.

This special second-order capability associated with agency freedom might be termed a personal identity capability (Davis, 2009, 2011). Its character as a second-order capability derives from its reflexive nature, or that the person takes herself and her capabilities as her object. That people are able to reflect upon themselves and their personal identities has long been a subject of research in social psychology that investigates how people employ self-concepts as representations of themselves (e.g., Markus and Wurf, 1987). The self-concept as a representation of personal identity acts as an organizing frame for the many different activities people engage in. However, this organizing frame is not thought to be static and unchanging. Rather it evolves together with the range of activities people pursue. That is, people operate with dynamic self-concepts, or in Sen's capability approach framework, the personal identity capability is a capability people develop together with all the first-order capabilities that they develop.

In Sen's capability approach, then, people are intrinsically worthy of being treated with dignity because they are essentially self-determining types of beings. This does not mean that people's lives and their conceptions of themselves are not also influenced by many other things. The point is that, were people's lives generally determined by forces beyond themselves, that is, were their lives largely socially and other-determined, then their normative value would be derivative of these other social forces. For example, a person's value could be seen as being determined by their contributions to a larger cause such as the advancement of science. Then it is this larger cause that is intrinsically valuable, not the people whose efforts are a means to it as an end who are thus only instrumentally valuable. In Sen's approach, however, when people exercise agency freedom, they make

themselves ends in the process of reflecting upon and deliberating over what they believe their goals should be. It is exercising this second-order, self-determining personal identity capability that invests the person exercising it with intrinsic value and dignity.

Note that dignity is the idea of being due respect, and respect in this regard is commonly accorded to what is seen to be valuable in itself (Donagan, 1977, Wood, 1999). Respect is different from other forms of approval where valuing something depends upon it contributing to the realization of something else valued in itself. Thus, in the capability conception of the person, what underlies the normative value of the person is being intrinsically worthy of respect and being treated with dignity. I return to this issue in the last section below where I argue that the utility conception of the person is only able to undertake instrumental forms of approval, and thus cannot explain care in terms of dignity.

4.2 The normative values of social embedded health care and the dignity of the person

I also see people as having dignity and deserving respect on account of the particular normative values arising out of care relationships in health I discussed above. The view is that certain types of normative values exist in health care systems because these values are emergent upon interaction between socially embedded individuals in care settings. What I then address in this section is how four particular values – equality, *ex ante* responsibility, human rights, and freedom in both the negative and positive senses – each support a normative conception of the person intrinsically worthy of being treated with dignity. I set out this explanation in relation to a capability conception of the person.

In the capability conception, an individual made up of many capabilities is a single person in virtue of being able to exercise a personal identity capability. What Sen's breakdown of different kinds of individual advantage and associated different capabilities provides us, then, is a broad structure to people's personal identities. The normative values I connect to these capabilities are accordingly values tied to people being able to have and develop their personal identities in terms of this structure of individual advantage.

Further, since a capability as opposed to the atomistic utility understanding of the person is a relational conception of the person, these normative values are framed in terms of relationships between people. I took as evidence of this that these values can be explained in collective intentionality terms or as what people would take to be the shared normative values underlying their interaction.

First, in the case of well-being achievement, individual advantage is a matter of attaining a minimum threshold level of achievement with respect to what is needed to survive as a human being. Anyone achieving this elementary level of well-being counts as a person in this very minimal sense, and all individuals are then equal by this single standard. People of course vary in terms of what the elementary requirements of well-being and survival involve, but the need to meet whatever those requirements are in each case is the same. Equality in this specific regard – treating equals as equals – is a base value for being a person. But being a person, even in this very basic sense, is still not instrumental to any other goal, and thus it remains something intrinsically valuable in itself. This gives the value of equality in the treatment of capabilities and health a specific role and interpretation, namely, as a value foundational to human dignity. In effect, were it not that all people are counted the same, and some were more valued than others, then the latter might be subordinated to the former, and only have instrumental value. Making well-being achievement a minimal requirement of being a person rules out this possibility.

Second, well-being freedom is distinct from well-being achievement in that it allows for differences between people regarding what they freely choose to do to produce individual well-being. Well-being is then understood not in terms of minimal requirements of survival but in relation to the exercise of freedom. Accordingly, since how people exercise freedom differentiates them, equality is no longer the value we should focus on to understand the nature of individual advantage in this case. Rather the focus becomes how individuals use their freedom to achieve well-being. Well-being, then, conditions the

exercise of freedom.[5] For this reason, I have associated *ex ante* responsibility with well-being freedom. The person has responsibility before action – *ex ante* – to exercise her freedom in a way that must be responsible to advancing her own well-being. This means that this freedom carries a burden of possible failure since freedom with a specific goal can always be inadequately exercised. The link to human dignity is consequently also different in this case. Any failure is the person's alone – the idea of personal responsibility – because the consequences of it accrue strictly to the individual person's exercise of freedom. I regard this as a further measure of the dignity of the person, that the person uniquely bears this burden of responsibility.

Third, in the case of agency achievement individual advantage derives from being able to achieve goals other than a person's own individual well-being. These can be other personal goals, such as the ability to be independent emphasized above, but can also be goals that concern others, such as the well-being of others or others' autonomy. What is thus characteristic of agency achievement is that a person's individual advantage resides in being able to abstract from her own well-being and act to achieve any sort of goal irrespective of whose it may be. That this form of individual advantage concerns the achievement and not just the pursuit of other goals is important, because this gives a general entitlement to people's goals. That individual advantage accrues to people in the achievement of people's goals then underlies the position that the normative value involved is human rights. There are of course many ways in which the concept of human rights has been explained, but here I simply interpret human rights as a broad entitlement to realizing human goals. That this is a right derives from this being a form of individual advantage. That this broad entitlement is a matter of human dignity follows from taking human goals as given and thus as intrinsically valuable.

Fourth, I turn to agency freedom, which I link to the value of freedom in both its negative and positive aspects. I argued in the last section that being able to exercise agency freedom underlies having a personal identity capability, because determining one's own

[5] In contrast, in the case of agency freedom, where people determine their goals, freedom instead conditions their goals, whether they are Well-being goals or other kinds of goals.

goals also makes the person self-determining, and being self-determining involves having and developing a self-concept. Since freedom must be understood as both freedom from external constraint and freedom to take control of one's self, for a person to be self-determining, both aspects need to be present. Indeed, not only must both aspects be involved, but the person must be able to know how to integrate them, understanding how they balance and when one or the other should be the focus. Needless to say, there are no special rules, nor easy ways of knowing how to proceed. The quality of being able to exercise agency freedom in this sense not something that can be explained but is a matter of what having and developing a personal identity involves. Thus I take this to be a special measure of human dignity as well, and see the person's management of their negative and positive freedom as being central to it.

4.3 The dignity conception of the person compared to the utility conception

In this paper, I argued that normative values associated with care in health systems arise out the interaction between people. The conception of the individual in standard health economics, however, is of an un-embedded, socially isolated individual. To the extent, then, that standard health economics associates normative values with health care, it restricts them to what relate to people's private concerns understood in terms of individual preference satisfaction, as in the QALY framework. This leads to the problem that normative criteria used to determine care, for example in the 'fair innings' approach that attaches 'equity weights' to different sets of QALYs (Williams, 1998; Culyer and Wagstaff, 1993), have a certain degree of after-the-fact arbitrariness about them. In contrast, the socially embedded individual approach is framed in terms of health capabilities, which are determined in care relationships. The different ways in which we explain these care relationships, according to the types of health capabilities we distinguish, then generate the normative values appropriate to the provision of care in each case.

The argument in the preceding section, then, is that the specific types of values and the normative objectives regarding care that I have identified using a capability approach

imply a particular normative conception of the person, namely, a person intrinsically worthy of being treated with respect and dignity. Here I follow others who have linked capabilities and the ideal of person-centered care with its emphasis on treating people with dignity (Entwistle and Watt, 2013). The ideal of person-centered care is well-established in health care, but saying what a 'person' is has naturally been less easy. The capability framework, however, provides a clear way of addressing what a 'person' because it allows us to say what is important in an individual being able to function as a person. I have further expanded on this idea by emphasizing both the role of a special, second-order personal identity capability (Davis, 2013), and by treating the four different types of capabilities people have as a personal identity structure that the person manages. The personal identity capability is a reflexive, second-order capability whereby the person takes herself and her first-order capabilities as her object. That there is such a structure to her capabilities follows from the distinction between well-being and other goals and the distinction between achievement and freedom to achieve in Sen's framework.

The basis for the characterization of the person as worthy of being treated with dignity derives from the idea of something being valuable in itself. A person able to judge herself and her capabilities in a reflexive manner makes herself intrinsically valuable and an object of dignity. Such a person is the focus of person-centered care health care. The focus of this paper was the micro basis for person-centered health care. I argued that the configuration of normative values I describe as working at the micro level in care systems work together at the macro level to make equity a foundational value for social policies underlying the development of health care systems.

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Table 1 – Classification of different types of health capabilities with examples

	Well-being	**Overall agency goals**
Achievement	*Well-being achievement* e.g., prenatal and neonatal care, children's vaccinations, etc.	*Agency achievement* e.g., social access for the disabled
Freedom to achieve	*Well-being freedom* e.g., chronic hypertension	*Agency freedom* e.g., women control of their fertility

Table 2 – Different types of health capabilities and corresponding shared intentions

Type of health capability	**Form of shared intention**
Well-being achievement e.g., prenatal and neonatal care, children's vaccinations, etc.	Generally shared intentions regarding capabilities all people should have
Well-being freedom e.g., chronic hypertension	'Local' shared intentions of health providers and patients about different health capabilities
Agency achievement e.g., social access for the disabled	Overlapping sets of shared intentions about a type of health capability in multiple domains
Agency freedom e.g., women's control of their fertility	Universal idealized shared intention

Table 3 – Health capabilities, shared intentions, and moral values

Type of health capability	**Form of shared intention**	**Moral values**
Well-being achievement e.g., prenatal and neonatal care, children's vaccinations, etc.	Generally shared intentions regarding capabilities all people should have	Equality for all
Well-being freedom e.g., chronic hypertension	'Local' shared intentions of health providers and patients about different health capabilities	*Ex ante* responsibility
Agency achievement e.g., social access for the disabled	Overlapping sets of shared intentions about a type of health capability in multiple domains	Human rights
Agency freedom e.g., women's control of their fertility	Universal idealized shared intention	Negative and positive freedom