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**CONCEPTUALISING HEALTH: INSIGHTS FROM THE CAPABILITY
APPROACH**

Forthcoming in *Health Care Analysis*

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Conceptualising Health: Insights from the Capability Approach

Introduction

Ongoing debate within the philosophy of medicine concerns how concepts central to healthcare (e.g. health, disease, etc.) should be defined. One of the difficulties of this debate is that various interested parties have different needs with respect to such concepts. Some take a theorist's perspective, and prioritise conceptual clarity and rigor. Others are more concerned with providing concepts that can be useful to real-life medical practice. And others are more concerned with wider policy and health-promotion issues, and seek a concept of health usable in a globalised context.

In this paper we want to suggest adopting a 'capability approach' to health and related concepts. Such an approach captures much of the best theoretical and conceptual work on these issues, while also being applicable to real life cases and actual practice. With roots in development ethics and economics, the capability approach is well-suited to policy-making and health-promotion in a global context.

Section 1: Accounts of health and disease.

Recent work on the concepts of health, disease and related notions has suggested that health in an individual is a matter of that individual having the resources to cope with her needs (Nordenfelt, 1987, 2001, 2007; Kovacs, 1998; Bircher, 2005). While there are differences in the details of such accounts, the basic idea seems plausible.

Advocates of this approach see it as an improvement upon the WHO definition of health in terms of 'complete physical, mental and social wellbeing' (WHO, 1948, preamble). They also see it as avoiding the difficulties of 'biostatistical' accounts of

health like Christopher Boorse's, which attempt to define 'health' and 'disease' in objective, scientific terms rooted in biology (Boorse, 1975, 1976, 1977, 1997), but which strike many commentators as unduly narrow and disconnected from people's experiences.

The WHO definition is said to be 'idealistic' and to 'give no help' (Bircher, 2005, 338). In saying that health is '*complete* ... wellbeing' it seems to make health an unreasonably high standard (Lewens & MacMillan, 2004, 664). It also requires that we have an independent grasp of the concept of disease, since it goes on to say that health is 'not merely the absence of disease or infirmity' (WHO, 1948, preamble). Bircher and Kovacs, by contrast, see any condition that falls short of health as disease. For them, health and disease are mutually exclusive and exhaustive, and thus one can be defined in terms of the other. Lastly, the WHO definition seems merely to defer the difficult conceptual work. Unless we have a satisfactory account of wellbeing, the definition of health is incomplete and ambiguous, but wellbeing is a concept no less contested than health.

The most notable rival view of health regards survival and reproduction as the basic functions of living organisms (Boorse, 1975, 57). Disease is any condition which constitutes 'deviation from the natural functional organization of the species' (Boorse, 1975, 59). The addition of 'natural' enables Boorse to avoid the objection that some conditions are diseases despite being statistically normal. Tooth decay, he explains, is not 'in the nature of the species ...[but] mainly due to environmental causes' (Boorse, 1975, 59). Not all objections are as easily dealt with, however: homosexuality is both statistically abnormal and an obstacle to reproduction. Whether or not Boorse's

account classifies it as a disease (as some think it will, see Lewens & MacMillan, 2004, 664) thus rests on whether or not homosexuality is ‘in the nature of the species’ or ‘due to environmental causes’.

A further problem for Boorse is that his selection of survival and reproduction as the central functions seems under-argued, at least in the human case. There are conditions, intuitively classifiable as diseases, which interfere with human functioning but not with survival or reproduction. Anne Gammelgaard offers incontinence as an example (Gammelgaard, 2000, 110). She questions whether any goals are ‘intrinsically valuable to an organism’ (Gammelgaard, 2000, 111). At the very least, it seems that many humans have a central interest in maintaining a wider range of functions than merely survival and reproduction.

Boorse believes that it is possible to use evolutionary biology to provide a scientific account of biological function (Boorse, 1977, 556–557). This is an integral part of his overall aim of bringing health and disease within the sphere of science. But this brings several problems. First, there are good examples of ‘diseases’ (intuitively so classified) that appear to be the product of natural selection, e.g. allergies (Gammelgaard, 2000, 113). Second, species-typical behaviour that is well-adapted (i.e. conducive to survival and reproduction) in one environment may well not be in another. Given that all organisms are the result of selection pressures their ancestors experienced in the past, it seems likely that some current species-typical traits are not well-adapted to the current environment. Perhaps this is particularly true at this point in history, given that humans have changed the environment in which we and other organisms live. Third, most evolutionary biologists see the gene as the unit of

selection, not the organism. This means that ‘there is no reason to assume that adaptations are primarily devoted to the needs of the organism’ (Gamelgaard, 2000, 113). Jozsef Kovacs goes further, noting that some species-typical traits may serve the interests of neither the organism nor its genes but the interests of rival organisms (Kovacs, 1998, 33).

An account of health in terms of having resources to meet needs thus seems more promising than both the WHO account and the biostatistical account. Such accounts have been defended by Lennart Nordenfelt, Jozsef Kovacs and Johannes Bircher. Nordenfelt’s most recent statement of his account is this:

A is completely healthy if, and only if, A has the ability, given standard circumstances, to reach all his or her vital goals.
(Nordenfelt, 2007a, 7)

‘Vital goals’ are elsewhere in Nordenfelt’s work identified as ‘the set of goals which are necessary and jointly sufficient for [A’s] minimal happiness’ (Nordenfelt, 1995, 90). While some vital goals (those related to survival) are identified as ‘basic’ (Nordenfelt, 2007b, 30) in general, it is factors relative to the subject that determine which goals are ‘vital’, since ‘the concept of happiness that I have adopted is a want-related concept, so that happiness can be seen as an equilibrium between the subject’s wants and the world as he or she finds it to be’ (Nordenfelt, 2001, 68). Nordenfelt is at pains to point out that he is not equating health and happiness. Rather, health is the possession (not necessarily the exercise) of various abilities, which together constitute the ability to realise vital goals (Nordenfelt, 2001, 68).

However, although potentially escaping the problems of the previous accounts, this account remains rather vague, and several questions need to be answered. Is it true, for instance, that the ability to achieve ‘vital goals’ is equivalent to the ability to ‘realise minimal happiness in standard circumstances’? It seems that one might have the latter but not the former, especially if one’s circumstances were sub-standard. In difficult circumstances one might have sufficient ability that one could be happy in better circumstances but not in the circumstances that one finds oneself in. What is to be the criterion of ‘standard’, in any case? It must be said that Nordenfelt displays an admirable willingness to ask these questions of his own theory, and to revise it in the light of doing so. For instance, he himself asks ‘Is it reasonable to relate health and happiness to each other in such a strong way as I do?’ (Nordenfelt, 2001, 71). He later comments in answer,

‘More is to be said about the relation between health and happiness. Is happiness the only reasonable ultimate anchor for the concept of health? What of the case for a notion of human flourishing closer to the Aristotelian eudaimonia than to my want-satisfaction notion of happiness? I leave these questions for the next revision of my characterization of health and illness’ (Nordenfelt, 2001, 118-119).

Kovacs proposes that Nordenfelt’s account needs to be improved. Kovacs suggests that Nordenfelt understands ‘standard circumstances’ to be the ‘typical environment, in which most of the people in a given society live’ (Kovacs, 1998, 36). But what if

that environment is itself toxic, whether physically, politically, or spiritually? In response to this worry Kovacs states that to be healthy is 'to adapt to reasonable social norms without pain and suffering' (Kovacs, 1998, 38). Nordenfelt himself is sensitive to this issue. While he acknowledges that 'standard circumstances' refers to a set of circumstances 'commonly presupposed within a culture', he now also speaks of 'reasonable circumstances', a term he describes as 'more openly normative'. However, he does not depart from the former in favour of the latter, preferring to see each as appropriate for different 'health discourses', and to use 'accepted circumstances' as a term covering both standard and reasonable circumstances (Nordenfelt, 2001, 68).

Like Kovacs and Nordenfelt, Bircher sees health as being able to cope with the circumstances in which one finds oneself: 'health is a dynamic state of wellbeing characterized by a physical, mental and social potential, which satisfies the demands of a life commensurate with age, culture, and personal responsibility. If the potential is insufficient to satisfy these demands the state is disease.' (Bircher, 2005, 336) This account is proposed explicitly as a rival to and improvement upon the WHO definition (Bircher, 2005, 339). The idea is that health is having enough 'potential' (composed of biological and acquired capabilities) to cope with the demands of your life. If you don't have enough, then you are diseased. Someone with less potential might be healthier than someone with more, if they faced fewer demands (Bircher, 2005, 338).

While the sort of view defended by Nordenfelt, Kovacs and Bircher introduces a welcome element of flexibility, there are still areas of deficiency. For example, one

might wish to reconsider whether health and disease are mutually exclusive and exhaustive. It might be, as the WHO definition stipulates, that there can be a gap between health and disease, such that although one suffered from no disease, nevertheless one did not have health. In addition, one might wonder whether in some circumstances one might have a disease and yet be healthy.

More specifically, it has been objected that Nordenfelt (and by implication the other similar theorists) has a notion of health that is too broad, lending itself to the medicalisation of non-medical difficulties. Thomas Schramme offers the example of Lily, an athlete who is successful, but fails to achieve ambitious goals (e.g. clearing heights of over two metres in the high jump). ‘Lily is unable to realize at least one vital goal, therefore she is not healthy, according to Nordenfelt’s definition.’ (Schramme, 2007, 14). This objection presses on Nordenfelt’s subjectivist way of identifying vital goals. This in turn requires consideration of which abilities matter to health. Should it be those abilities that the subject herself values, or is another criterion available? Sometimes Nordenfelt says things that are suggestive of a move away from subjectivism: ‘A vital goal is not one that the agents simply wish to attain. Instead, it is a state of affairs which has a much deeper relation to the personality of the subjects and has to do with what is good for them in the long run’ (Nordenfelt, 2001, 111). He also comments: ‘More is to be said about the nature of the ability embedded in the notion of health. Should it be solely characterized in terms of a second-order ability [i.e. the ability to acquire an ability to do something], or should we again consider a disjunctive definition to the effect that health is sometimes identical with first-order ability?’ (Nordenfelt, 2001, 118). We wish to suggest that

the capability approach may provide the resources to pursue answers to these questions.

Before we turn to discussing the capability approach, there is another distinction that is worth noting in the project of defining key concepts in healthcare is that between various different phenomena associated with ill-health. Boorse made a distinction (later abandoned) between ‘disease’, which is a scientific, objective term and ‘illness’ which is subjective and normative (Boorse, 1975, 61). Nordenfelt accepts this distinction, but wishes to insist that illness is the primary notion, and that ‘disease’ is derivative (Nordenfelt, 2007a, 7).

Andrew Twaddle’s earlier (1968) tripartite distinction between ‘disease’, ‘illness’ and ‘sickness’ has been influential and still has able advocates (see for example Hoffman 2002). Like Boorse’s, the tripartite distinction sees ‘disease’ as a matter of objective fact. Paradigm cases of being diseased would include physical trauma and infection. ‘Illness’ is the subjective experience of ill-health. Someone with an infection who is unaware of any symptoms is diseased, but not ill. Possibly one may be ill but not diseased: experience symptoms which are unpleasant, but for which no biological basis exists. Being ‘sick’ is a social matter – to be sick is to have one’s role in society altered. This can happen in a variety of ways: exemptions and permissions are good illustrations, e.g. being allowed to miss work. The change in role is not always so benign. The sick may be shunned and barred from various social interactions.

The utility of the tripartite distinction is in accounting for cases in which one or two of the three categories apply to an individual but the others do not. (Hoffmann gives

examples of every possible combination (Hoffmann, 2002, 658-663)). Thus it is useful to have the conceptual resources and terminology to say that while, e.g. fibromyalgia or whiplash are experienced as illnesses, and accorded the 'sick role', medical science cannot find any disease associated with them, i.e. any underlying physiological cause for the symptoms. Equally one can say that someone whose cancer is detected by screening before they experience any symptoms is diseased, and will be accorded the sick role, even though they are not ill. The use of this terminology is however somewhat artificial. It seems likely that we would be able to express the same thoughts in these cases even if we did not use the suggested terminological distinction. Certainly the terminology is revisionist, while the points made using it seem relatively easy to grasp. The tripartite distinction is artificial in another way too. It requires us to embrace a rigid objective/subjective, fact/value distinction. 'Disease' is wholly objective, and subjective and phenomenological elements are reserved for (or relegated to) the category of 'illness'. 'Illness' in turn is subjective, normative and phenomenological – but can we not see these as also belonging to the realm of fact? Perhaps the tripartite distinction is too neat, too clear-cut. It imposes a way of thinking even as it permits certain thoughts to be clearly expressed. Furthermore, it may be more theoretically satisfying than practically useful.

As things stand, then, recent literature on health and related concepts exhibits a degree of convergence on the thought that health is the ability to cope with the demands of life, or the ability to exercise key functionings. Ill-health can take various forms which can be subtly inter-related, but which all stem from an impairment in the ability to function in order to meet the demands of life. The details of how such an account

would work remain to be fully elaborated. Happily, these issues have been addressed in some detail in a parallel literature that those interested in health may be able to make use of. In studies of welfare, wellbeing, development and related fields, similar conceptual issues have been investigated via what is known as the ‘capability approach’. We shall argue that the capability approach is promising as an approach to health and disease, and may avoid the difficulties that remain in the accounts discussed above. It can be used to capture the key insight of the best recent work on health. It lends itself well to the demands of health-care practice as well as to theorising about health-related concepts. It is especially apt for use in the increasingly globalised context in which the WHO and other organisations work.

Section 2: The capability approach

The capability approach arose in the fields of development and economics and is primarily associated with the work of Amartya Sen and Martha Nussbaum, although it has been broadly adopted in both theoretical work regarding quality of life and human flourishing as well as influencing the development and implementation of policy and practice, such as its obvious presence in the thinking behind the UNDRs.

The capability approach arose out of dissatisfaction with the available tools for evaluating and monitoring development, in particular those derived from utilitarian agendas and aggregate measures, and those based on asserting a list of ‘primary goods’ (Sen, 1979). For example, Sen is critical of utilitarian models in ways which draw on standard criticisms of utilitarianism, such as not accounting for the separateness and diversity of persons and the failure of such models to account for distributional inequalities. (Sen, 1979, p202; Alkire, 2002, p2). Likewise desire and preference satisfaction models are rejected as “utility...is concerned with what these

things do to human beings, but uses a metric that focuses not on the person's capabilities but on his mental reaction" (Sen, 1979, p218).

In addition, models which focus on equal distribution of goods (such as the Rawlsian model of 'primary goods') are rejected for taking "little note of the diversity of human beings" (Sen, 1979, p215). He asserts that "if people were basically very similar, then an index of primary goods might be quite a good way of judging advantage. But, in fact, people seem to have very different needs varying with health, longevity, climatic conditions, location, work conditions, temperament, and even body size (affecting food and clothing requirements)" (Sen, 1979, p216). Accordingly a primary goods approach "suffers from fetishist handicap in being concerned with goods, and even though the list of goods is specified in a broad and inclusive way, encompassing rights, liberties, opportunities, income, wealth, and the social basis of self-respect, it is still concerned with what these things *do* to human beings" (Sen, 1979, p218).

In contrast Sen asserts that his approach accesses actual capability and quality of life since what "we are really interested in what persons are actually able to do or be...not in the pounds of rice they consume" (Alkire, 2002, p6). He claims that the capability approach makes "room for a variety of human acts and states as important in themselves (not just *because* they may produce utility, nor just to the *extent* that they yield utility)...On the other side the approach does not attach direct – as opposed to derivative – importance to the *means* of living or *means* of freedom (real income, wealth, opulence, primary goods or resources)" (Sen, 1993, p33).

For Sen, all these approaches fail to take account of “basic capabilities”: the actual capability of agents to ‘be’ and to ‘do’ (Sen, 1979, p218). Much of the capability literature involves discussions of valuable ‘beings and doings’ and is “based on a view of living as a combination of various ‘doings and beings’” (Sen, 1993, p31). Beings and doings are conceived of in terms of the opportunities afforded by the social context as well as by individuals’ capabilities. Capability then is about what a person is able to be and do determined by the background social context, the endowments of the individual and opportunities and choices afforded to the individual. It is “the alternative combinations of things a person is able to do or be – the various ‘functionings’ he or she can achieve” (Sen, 1993, p30); a person’s “actual ability to achieve various valuable functionings as a part of living” (Sen, 1993, p30). For Sen taking account of these actual capabilities is “an indispensable and central part of the relevant informational base” (Sen, 1993, p30) if one is to have a realistic conception of actual wellbeing, equality or development and thus to structure realistic and effective development policy.

Capability refers to a set of beings and doings or ‘functionings’, as they are often termed. The particular combination of functionings (the functionings set) is variable by individual and context as is the resulting construction of capability.¹ Accordingly, the “*capability* of a person reflects the alternative combinations of functionings the person can achieve, and from which he or she can choose one collection” (Sen, 1993, p31). The flexibility or freedom to move between sets of functionings and to value different functionings (including freedom) in various orders is prized on this approach and, “capability refers to a person’s or group’s *freedom to* promote or achieve

¹ Boorse, of course, sees health as a matter of being able to exercise key functionings. But he restricts these functionings to survival and reproduction (Boorse, 1975, 57). Anne Gammelgaard criticises this narrow range as unsupported by biology (Gammelgaard, 2000, 110 - 113).

valuable functionings” (Alkire, 2002, p6). It is “a set of vectors of functionings, reflecting the person’s freedom to lead one type of life or another” (Sen, 1992, p40).

Freedom is key for Sen and concerns the actual capabilities that one is afforded, not just with individual control and choice. On this model freedom includes social and political policies which engender greater or lesser freedoms. To illustrate this Alkire uses Sen’s example of ‘freedom from malaria’: “if, given the choice, we *would* choose to live in a malaria-free environment, then *ceteris paribus* a public programme to drain malaria ponds *does* indeed enhance our freedom, even if we were not in fact asked, because in the absence of this public programme we would not have the effective freedom to live in a malaria-free environment” (Alkire, 2002, p7). Thus freedom in the capability approach indicates more than simply autonomous, individual choice as championed by the liberal model. Freedom in this approach is conceptualised as positive as well as negative, hence “‘freedom from hunger’ or ‘being free from malaria’ need not be taken to be just rhetoric...there is a very real sense in which the freedom to live the way one would like is enhanced by public policy that transforms epidemiological and social environments” (Sen, 1993, 44).

A key aspect of Sen’s capability approach is its flexibility and pluralism. In application it is “rather culture dependent, especially in the weighting of different capabilities” (Sen, 1979, p219). This breadth of application is criticised by some as being too minimal since it requires further working out of specific capabilities before being applicable in any context.² Thus the valuable functionings which make up

² For example, Nussbaum is critical of the indeterminacy of Sen’s version of the Capability Approach and argues that “Sen needs to be more radical ...by introducing an objective normative account of human functionings and by describing a procedure of objective evaluation by which functionings can be assessed for their contribution to the good human life” (Nussbaum, 1988, p176)

capability are open to negotiation and change from one context and individual to another. Were this not so “we might be as worried about the rich person fasting as about the starving poor” (Sen, 1993, p45) – a failure similar to the earlier criticisms of the primary goods model. The construction of capability in a particular context is determined by the chosen set of functionings, some of which “are very elementary, such as being adequately nourished, being in good health, etc., and these may be strongly valued by all...others may be more complex, but still widely valued, such as achieving self-respect or being socially integrated” (Sen, 1993, p31). Thus “capabilities may relate to things near survival (the capability to drink clean water) or those which are rather less central...The *definition* of capability does not delimit a certain subset of capabilities as of particular importance; rather the selection of capabilities on which to focus is a *value judgement*” (Alkire, 2002, p8). Furthermore the selection of capabilities takes place at a number of levels – some collective, some individual: “individuals may, however, differ a good deal from each other in the weights they attach to these different functionings – valuable though they may all be – and the assessment of individual and social advantages must be alive to these variations” (Sen, 1993, p31). Thus choices about capability, about the actual set of functionings, need to be made in different contexts and by different individuals and groups according to the values and priorities of that context. The resulting definition of capability is not predetermined by the mere adoption of the approach and, accordingly “there is no escape from the problem of evaluation in selecting a class of functionings in the description and appraisal of capabilities” (Sen, 1993, p32).

Sen argues that the inherent pluralism, or ‘incompleteness’ of the capability approach is an advantage which allows applications in multiple contexts and within different value-frameworks. He claims that the “capability approach can be used with different methods of determining relative weights and different methods for actual evaluation” (Sen, 1993, p48). Such indeterminacy while perhaps less theoretically satisfying does increase the potential applicability of the approach, which is a core concern for its advocates. For example, Alkire suggests that the ‘focal problem’ is “the need for a methodology by which Oxfam field staff in Pakistan could identify which ‘valuable’ capabilities a development activity...had expanded or contracted” (Alkire, 2002, p3). Thus the capability approach is concerned “not only with normative and empirical development theory but with development policy and practice” (Crocker, 1992, 587).

Section 3: Applying the Capability Approach to Health

There are a number of similarities between capability as it is thought of in development and in the context of health. Given its theoretical and practical application, its predominance in related fields (e.g. wellbeing, quality of life) and its potential usefulness in healthcare theory, policy and practice, it is perhaps surprising that it has not received more attention. Although some thinkers have referred to it, for example when thinking about quality of life or the place of health in development, little has been done to apply the approach to definitions of health as such. (Brock, 1993; Verkerk, Busschback and Karssing, 2001; Ruger, 2004) Following the capability approach itself health has tended to be seen as one of the ‘functionings’ which make up capability rather than the more radical solution we suggest which is to consider what the approach could offer us as a way of conceiving of health as such. The suggestion here is to consider health not as a single ‘functioning’ but as

‘capability’ constructed from various possible functionings, in other words as a collection of valuable components which can be constructed in a variety of ways.³

The capability approach may have the potential to improve our conception of health in the following five ways: First, the capability approach offers a model which rejects one dimensional definitions and thus allows us to escape some of the problematic over-narrow and over-broad definitions of health. Second, it offers a model which allows the set of ‘functionings’ which constitute the capability set to change depending on individual and group context. In the health context this allows a ‘basket’ of health goods which change between contexts and individuals, allowing certain constituents to be global, others local and others individual. Third, relatedly, it permits one to adopt a conception of basic functionings (for our purposes health functionings), equivalent to the way the approach has been used to identify basic needs (but is not limited to this, nor does it see this ‘set’ as the only possible or valuable set of functionings). Fourth, it has the potential to be used globally as “one can...analyse the capabilities of a rich as well as a poor person or country, and analyse basic as well as complex capabilities” (Alkire, 2002, p9): a necessity when considering the need for definitions of health to be globally applicable. Fifth, it is practically relevant, as illustrated by the influence of the capability approach on the Human Development Reports: drawing directly on the Capability Approach the UNDP states that “Human development is a process of enlarging people’s choices. Enlarging people’s choices is achieved by expanding human capabilities and functionings” (1998).

³ From here on, when we refer to ‘capability’, we mean ‘health considered as capability’ and not capability more broadly construed. How exactly these two concepts relate to each other is a major question that we hope to address in future work.

Some of these similarities are more relevant to the current discussion than others in that they speak directly to the theoretical and practical issues outlined at the beginning of this paper: with reasons one, two and three addressing primarily theoretical concerns, and reasons four and five showing global and practical applicability. In short a capability approach to health offers a middle way through the theoretical definitions of health as it is not subjectivist but does potentially accommodate the real needs of actual individuals thus avoiding objectivist critiques.⁴ Moreover, it has a sound theoretical basis and the practical applicability required by health care policy. These benefits of a capability-type understanding of health are demonstrated in the following examples. In one type of example, the same condition obtains but in different social circumstances. In another type of example, the attitudes and needs of the individuals affected differ, making crucial differences to their level of health. This sort of situation is difficult to account for using the definition of health proposed by Kovacs. Bircher's proposal and the account of Nordenfelt would fare better, but not be as good at dealing with these phenomena, we suggest, as the capability approach.

First, an example concerning social/political circumstances. Consider two people with diabetes. Paula lives in an industrialised nation with a national health service. She receives guidance and support relating to her lifestyle, and also free insulin. James lives in a developing nation whose health service is greatly over-stretched. He has no access to health-care personnel trained specifically to deal with diabetic patients. He has to pay part of the cost of his insulin. This is difficult, and supplies of the drug are often low and he cannot obtain it. Although Paula and James both suffer

⁴ This potential is at the heart of the promise we see in taking a capability approach to health. However, detailed exploration of this claim is beyond the scope of this paper, and will be addressed in future research.

from the same disease, they have different levels of health which will increasingly diverge.

The capability approach can accommodate these differences. One might try the tripartite distinction to account for the different experiences and realities faced by James and Paula, but the capability approach captures what is going on equally well without imposing such a rigid conceptual structure. From the perspective of the tripartite distinction, while Paula is diseased, she is only slightly ill, if ill at all. There are few activities that she cannot pursue: she plays tennis, works etc. If she manages her diet and takes the necessary insulin, her disease rarely causes illness. Many of her colleagues do not assign the 'sick role' to her, since they are not aware of any reason to do so. James does not have the sick role assigned to him even though he is ill as well as diseased. He needs to continue to work to be able to afford insulin. If he fails to show up, he will lose his job. Because he cannot get enough insulin, and because it is difficult for him to live the right sort of lifestyle, James develops further symptoms. These worsen over time: he develops nerve damage, cardiovascular disease, kidney disease and damage to his sight. So there is a dramatic difference in how Paula and James are affected. Because of her social and political circumstances Paula's capability is hardly affected, and she considers herself a healthy person. Her capacity to exercise some functionings is diminished, but she does not regard these as especially important. James's capability is greatly affected in a vicious circle of illness reducing capability leading to increased illness. The functionings affected are central ones, and a great many of James's key goals are adversely affected.

Another good example of the importance of social context is loss of a sense-modality, e.g. blindness or deafness. The impact of blindness on health is significantly affected by the degree to which, for example road and building design, the provision of public information and the provision of schooling are designed with blind people in mind. A blind person's capability can be increased by living in circumstances in which it is easier to function. A blind person in a more difficult environment is impaired to a greater degree.

The second type of example relates not to social environment but to the individual. The extent to which any given condition has a negative impact on a subject's health will depend in part on their attitudes and goals. Consider two people who are completely deaf. Jane went deaf in middle age, after a successful career as a record producer. She experiences her deafness as a profound loss of capability, since hearing was of central importance in both work and leisure. Despite good support she feels very much worse off than she was. Jane's case can be contrasted with real-life cases of deaf people who do not experience their condition as reducing their capability. In one widely-reported case, a deaf lesbian couple deliberately decided to have a deaf baby by using sperm donated by a friend who was deaf (Spriggs, 2002; Levy, 2002; Anstey 2002). They argued that deafness is a culture, not a disability, and that wanting to have a child who could be part of their culture was analogous to a black couple choosing a black sperm donor to ensure that they had a black child (Levy, 2002, 284). Far from thinking of deafness as reducing their health, this couple argued that being able to hear would constitute a lack of capability in their child. A hearing child would be unable to participate in deaf culture in the way that a deaf child could.

These examples demonstrate the flexibility a capability approach to health has. Its insights can be adapted to help us to understand which goals and needs it is important to meet: which functionings are relevant to the issue of health. It steers a course between the scientific objectivism of the biostatistical approach and the more subjectivist views of Nordenfelt and Kovacs. It allows a subjective element to be involved in objective matters, such as whether or not a given condition should be considered to be ill-health: within the capability approach a condition may or may not constitute disease depending on whether it constitutes a lack of capability for that individual in those circumstances. Thus the capability approach can make subtle distinctions like those captured by the disease/illness/sickness distinction, without being trapped into the conceptual straitjacket that the tripartite distinction brings with it. Thus, although it requires further exploration and elaboration we suggest that adopting a capability approach to health may help us to advance the current debate, while incorporating key insights achieved in that debate.

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