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The metric and the threshold problem for theories of health justice: A comment on Venkatapuram

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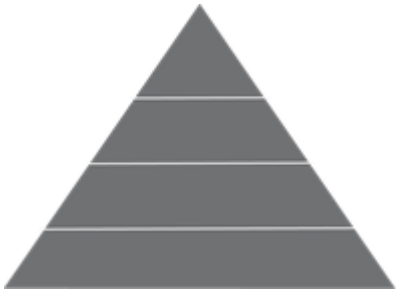

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The metric and the threshold problem for theories of health justice: A comment on Venkatapuram

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ABSTRACT:

Any theory of health justice requires an account of what areas of social life are important enough to be of public concern. What are the goods that ought to be provided as a matter of justice? This is what I will call the metric problem. The capabilities approach puts forward a particular solution to this problem. In this paper I will discuss some issues of such an approach in relation to Sridhar Venkatapuram's well-known theory. Another problem I examine is how to determine a threshold of provision within a theory of justice. What is enough in terms of health justice? I argue that we need such a threshold to avoid healthism, the expansion of the pursuit of health over and above the treatment and prevention of disease. This is an especially pertinent problem in public health, which is also the context of Venkatapuram's theory.

Keywords: Venkatapuram, public health, health justice, capabilities approach, healthism, sufficientarianism

The metric and the threshold problem for theories of health justice: A comment on Venkatapuram

One of the many benefits of Sridhar Venkatapuram's book is to bring together the debate on health justice with issues in public health. It is vital, for instance, to see health as a good that is partially determined – not only be treated – by social means. In other words, health is not a solely natural good. It ought to be acknowledged that there are social determinants of health, which – however indirect – impact the health conditions of citizens. This implies that health justice does not stop at doctors' practices or hospital doors, but needs to be taken to the heart of social institutions. This acknowledgement, however, does not already imply a necessity to tackle all possible determinants of health as a matter of justice. For a theory of health justice and more generally for any theory of justice, we need an account of what areas of social life are important enough to be of public concern. This includes a way of measuring the success of policies in dealing with justice issues in these areas, as well as an idea of how much we owe to each other in these areas. The first issue is the problem of identifying a metric, as I would like to call it, and the second is the problem of setting a threshold. Venkatapuram also sees the need to discuss these problems and hence in the following comment on his fine book I focus on these two issues. I see my comment as having a friendly outlook; there is a lot I agree with, but I believe Venkatapuram could improve his theory even more. More concretely, I believe he abandons the negative notion of health as absence of disease too quickly. This is related to the metric problem and his wide notion of health that defines the area of justice. In addition, I will claim that a focus on disease can also help us in sticking to a minimal approach that sets a threshold for claims of justice.

1. THE METRIC PROBLEM

Inequalities have to be measured or assessed in relation to a standard of comparison. Inequality per se does not exist, only inequality in certain respects. When discussing justice, we are normally worried about inequalities between people in normatively relevant respects, such as access to education or other beneficial goods. This poses the problem of identifying an "evaluative space", as Sen called it,[1] or of a "currency" of social

[1] A. Sen. 1992. *Inequality Reexamined.* Oxford: Clarendon Press: 2, 20 and passim.

justice, to use Jerry Cohen's memorable phrase.[2] This general currency, for Venkatapuram, is set by capabilities, where his specific focus on justice is the capability to be healthy.

One of the problems that have been discussed in the literature concerning the capabilities approach is its usefulness on providing a metric that will allow for making comparisons between individual persons or groups of people.[3] Although for Sen a major benefit of the capabilities approach seems to be its very capacity to provide such a measure, others are more sceptical that this is possible without reverting to a perfectionist ideal.[4] Especially when listing concrete capabilities like Nussbaum, the required commonality of the capabilities currency seems to disappear. For instance, how does a person who is deprived of access to books, and hence apparently suffers from an impairment regarding the capability of "being able to use senses, imagination and think", fare in contrast to a person who has no "control over [her] material and political environment". Capabilities seem to be simply too diverse to form a single currency, at least when they are given a specific content. So Sen's version, which does not provide content, seems to allow for a common currency, but at the price of being too abstract. Nussbaum's version, on the other hand, allows evaluations of certain conditions as bad, in case they do not secure basic capabilities, yet makes it hard to see how we could make interpersonal comparisons between different sets of capabilities that people can access. Yet without these comparisons it seems difficult to determine unjust inequalities in contrast to unjust insufficiencies.

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[2] G.A. Cohen. On the Currency of Egalitarian Justice. *Ethics* 1989; 99: 906–944.

[3] Both the metric and the threshold problem have been addressed in the relevant philosophical literature, though usually with a more general focus on justice and the capabilities approach as such, whereas my concern is more restricted to health care. See, e.g., F. Comim et al., eds. 2008. *The Capability Approach: Concepts, Measures and Applications*. Cambridge: Cambridge University Press; H. Brighouse & I. Robeyns, eds. 2010. *Measuring Justice: Primary Goods and Capabilities*. Cambridge: Cambridge University Press.

[4] Cf. R. Arneson. Equality and Equal Opportunity for Welfare. *Philosophical Studies* 1989; 56 (1): 77 - 93; M. Clayton and A. Williams. Egalitarian justice and interpersonal comparison. *European Journal of Political Research* 1999; 35: 445–464.

It seems to me that Venkatapuram tries to circumvent this problem by endorsing Nussbaum's list, but condensing it in one meta-capability, which is then supposed to secure the required common metric of numerous different capabilities. This is the meta-capability to be healthy. Venkatapuram talks about health in a specific way that needs some clarification. This becomes obvious when considering Nussbaum's list, which includes in addition to the mentioned two capabilities items such as the ability to "express concern for other species" or to "have social affiliations that are meaningful and respectful". The latter are not straightforwardly linked to the notion of health, and some have therefore objected that it makes the notion of health all-encompassing.[5] Yet, in fairness, Venkatapuram himself makes quite clear that he regards health to be a welfare notion, not a medical concept. The rationale for doing this is, at least partially, the ample evidence we find in social epidemiology regarding the causes of health. According to these findings, health is determined by many different factors that have to do with living conditions, lifestyle, even political circumstances, and so on. So it does not seem so problematic, after all, to bring the list of capabilities under the umbrella of being healthy.

I will come back to this welfare notion of "being healthy" shortly. Here I want to stress that the move to think of the list of Nussbaum's capabilities under the common rubric of being healthy might indeed help in identifying a solution to the metric problem, because in social epidemiology and public health policy scientists and practitioners alike face the very same problem. When studying inequalities in health and promoting policies that tackle inequalities we need ways to measure these inequalities. So it seems fair to say that the move to use the notion of a meta-capability to be healthy might raise theoretical concerns regarding its expansiveness, yet at the same time put the capabilities approach in the vicinity of a research and policy area that has developed some pedigree in dealing with the metric problem. In the next section I will focus more closely on the notions of health and being healthy. As will be seen, Venkatapuram's reading is in line with the perspective of public health.

1.1 *Public health perspective and the notion of health*

[5] L. Nordenfelt. Standard Circumstances and Vital Goals: Comments on Venkatapuram's Critique. *Bioethics* 2013; 27 (5): 280-284.

Venkatapuram rejects the common medical interpretation of health as absence of disease and endorses a "welfare" notion of health, in virtue of his alignment with Lennart Nordenfelt's theory of health. Although I am myself a defender of a naturalist position within the debate on the concepts of health and disease, I want to focus, in this section, on Venkatapuram's positive description. I also happen to believe that the naturalist account of health as absence of disease and the "holistic" theory of health à la Nordenfelt are in fact compatible, as they provide different perspectives on health. So there is no need at this point to defend the naturalist account against Venkatapuram's charges.[6]

Venkatapuram's theory is in line with the gradualist reading of the concept of health, which can also be found in (the so-called "new wave" of) public health. This is not surprising, as Venkatapuram is strongly influenced by the public health paradigm. It is important to understand that the concept of health is here understood in a special sense, which could be seen as discontinuous with general medicine.[7] In medicine, health is commonly understood in a negative fashion, as the absence of disease, or as medical normality. This is a minimal and absolute concept of health. A person is either healthy or not, there are no grades of health, though there might be grades of disease, of course. In order to be regarded as healthy, it is merely necessary not to be in any pathological condition. To be sure, there are attempts to conceptualise health in a positive way, for instance in the well-known formulation of the World Health Organisation "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Yet this definition has had no impact on medical theory or practice

[6] But see T. Schramme. A Qualified Defence of a Naturalist Theory of Health, *Medicine, Health Care and Philosophy* 2007; 10 (1): 11-17,

[7] The conceptual differences between a public health perspective and a medical perspective on health have been acknowledged in the literature, for instance in S. Holland. 2015. *Public Health Ethics. Second Edition*. Cambridge: Polity Press; T. Abel & D.V. McQueen. 2013. Current and Future Theoretical Foundations for NCDs and Health Promotion. In *Global Handbook on Noncommunicable Disease and Health Promotion*. D.V. McQueen. ed. New York: Springer: 21-35.

and has actually been criticised for its lack of distinction between well-being or happiness and medical health.[8]

The concept of health in public health differs from this medical viewpoint in several important respects. It is a relative or gradable notion, and it applies to groups or populations.[9] A person (or group of persons), in this perspective, can be more or less healthier than another person (or group of persons). Usually public health experts focus on particular socio-economic groups, for instance unemployed persons or single mothers. So when epidemiologists refer to population health they mean the statistically aggregated sum of individual health traits or health statuses. The way these groups or populations are determined depends on the particular purpose of a study. Ultimately these considerations depend on hypotheses about social or socioeconomic determinants of health, or – to use another expression familiar to a public health perspective – the "causes of causes" (of health status). Hence epidemiologists end up with findings about possible correlations between particular circumstantial aspects of citizens and their health conditions. Findings may be sought regarding socio-economic aspects, such as income, educational background or gender, or behavioural aspects, such as lifestyle and diet. With these statistical correlations it is possible to make comparisons between populations regarding their health, even on an international level. Obviously it is also possible to compare different policies in tackling those inequalities. In more popular publications[10] public health scholars then end up with simple slogans, such as "inequality is bad for your health", or "uneducated people die younger", which only makes sense from a population perspective, because a person who is worse off than others is not necessarily less healthy or an uneducated person does not have to die younger than others.

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[8] D. Callahan. The WHO Definition of 'Health'. *The Hastings Center Studies* 1973; 1(3): 77-87; see also S. Venkatapuram. 2011. *Health Justice: An Argument from the Capabilities Approach*. Cambridge: Polity Press: 66.

[9] Volker Schmidt similarly uses the distinction between negative and positive health to contrast the medical system and the health system, which are not always in congruence; see V. Schmidt. Public Health Ethics. Problems and Suggestions. *Public Health Ethics* 2015: 18-26. There is further overlap between Schmidt's and my own paper.

[10] For instance M. Marmot. 2004. *Status Syndrome: How Your Social Standing Directly Affects Your Health.* London: Bloomsbury.

The comparative perspective of public health depends, up to a point, on the fact that people can have certain dispositions to fall ill. A smoker, for instance, is more likely than a non-smoker to suffer from any lung disease. A person who works out and is generally fitter than others is less likely to catch a cold than others. Epidemiological research also establishes correlations between external environments and health conditions. For instance, a dark and unpleasant home, or a very stressful work environment, might increase the chance to fall ill.

In order to distinguish grades of health the perspective of public health needs standards of comparison. This is the metric problem again, here cropping up as a problem in public health. Before we have a closer look at how the metric problem is dealt with in public health, we should briefly return to Venkatapuram's account. He supposedly has found the common currency in the capability to be healthy as the sum of capabilities on Nussbaum's list. Yet, it seems unclear how Venkatapuram's interpretation of being healthy allows for interpersonal, or intergroup comparisons between levels of the capability to be healthy. At one point he says that the "metric is the social bases of the capability to be healthy".[11] This might suggest that it is not the level of health that is assessed, but the social conditions that supposedly underlie grades of health. In public health the social bases are of interest only insofar as they have an impact on health – this is precisely what social epidemiology tries to establish: the social determinants of health. Yet, if being healthy is conceptually tied to a level of certain social conditions, namely having Nussbaum's capabilities, then there is no need for empirical research on social determinants of health, because the social bases of being healthy are necessarily the conditions set in the list of capabilities.

There is some scope for claiming that social epidemiology in fact establishes a strong coincidence of the actual social determinants of health and Nussbaum's list of capabilities. Yet research in public health operates with a different notion of health. It is a gradual notion, as has been explained, but it is not a welfare notion of health that includes all welfare-related social conditions as aspects of health. For Venkatapuram, living in worse social conditions that are specified in the list of capabilities apparently means being less healthy. For the perspective of public health this can only be said if the social conditions actually have an impact on people's health. It is not a conceptual point but a statistical correlation that is to be established before drawing a connection

[11] Venkatapuram 2011, op. cit. note 6, p. 144.

between social conditions and health. Impact on health, in social epidemiology, is measured in terms of impact on organismic function and causation of disease, i.e. in the classical medical sense of health. It is only after these social determinants are being established that the gradual and population-oriented notion of health takes hold. People are then seen as less healthy if they live in certain conditions or pursue certain lifestyles that tend to cause disease.

The upshot of this is that Venkatapuram seems to rely on a presumed congruence of the social bases of health, as established by social epidemiology, and Nussbaum's list of capabilities, which then are declared to be the social bases of the capability to be healthy, as he conceives it. The metric problem has apparently been solved by him via drawing a parallel with the public health perspective. Yet, there are some problems in taking over such a perspective, and in the following paragraphs I would like to show how the metric problem, and the way it is addressed in public health, might imply a need to revert back to traditional health criteria we find in medical science.

1.2 *Measuring health*

In what respect can a person (or group) be healthier than another? What may be criteria for determining grades of health? This does not allow for a straightforward answer. In the definition of the WHO for instance the respective level of health is determined by a subjective state of well-being. This seems difficult to compare between persons or between different states of the same person, though there are now many efforts to turn even happiness into a quantifiable measure.[12] Also, it seems inadequate to call someone healthier merely because he feels better. We know that people can actually feel well and yet suffer from quite severe diseases, especially when these are yet symptomless.

To be sure, these challenges regarding the measurement of levels of health are very difficult to surmount. This is because health is such a complex aggregation of different aspects. We can only compare people in certain respects; we can never say whether they are more healthy than others *tout court*.[13] Is someone with an irritable lung but a robust

[12] D. Kahneman. 1999. Objective Happiness. In *Well-Being: The Foundations of Hedonic Psychology*. D. Kahneman et al. eds. New York: Russell Sage Foundation: 3-25.

[13] D.M. Hausman. Measuring or Valuing Population Health: Some Conceptual Problems. *Public Health Ethics* 2012; 5 (3): 229-239.

psyche less healthy than a marathon runner experiencing bullying at work? Such questions cannot be answered unless we focus on certain aspects of functioning. Public health usually works with only some particular health aspects, such as mental resilience or physical fitness. It also relies on proxies of these criteria, since they cannot easily be directly measured; hence public health for instance collects data about frequency of visits to a doctor or numbers of days on sick leave. Finally, there is a methodological problem of collecting data in epidemiology, which focuses on populations, not individual persons. The focus on populations requires certain abstractions for purposes of generating statistical data. A common statistical measure for comparing health of certain groups is life expectancy. Obviously here it is not individual health that is measured and compared but a heavily modified proxy for health conditions, which is also generalized over particular populations.

So in one sense, the public health perspective might come to Venkatapuram's help, since it has dealt with the metric problem for quite a while and proposed solutions to it. Yet, it apparently does not so much speak of the health status of people, but about proxies for health, even if understood broadly from a welfare point of view. Useful criteria for comparing health levels seem rather to be measures that have to do with the organismic functions of human beings, such as lung capacity, metabolism, memory, or resilience. The more effectively these mechanisms function, the healthier a person is. It is true, of course, that these internal resources of people are at least partly determined by social conditions. This is the valuable finding of social epidemiology, which Venkatapuram also draws attention to: the social determinants of health. But when establishing the determinants of health we still need a medical notion of health. To establish certain social conditions as a metric of the capability to be healthy requires a lot of derivation and statistical data, which is a contested practice. So it might be wise to be very cautious in establishing a notion of the capability to be healthy, and in determining its content via Nussbaum's list.

There is also, finally, a problem of a tunnel view involved. If the capability to be healthy encompasses "everything" that is good for people, it suggests a limitless value of such capability. But it seems more plausible and indeed more helpful for political purposes if we subscribe to a multi-value view, where health is one of many social values. From Venkatapuram's perspective, we cannot even pose the question as to how valuable the capability to be healthy is to us.

There is a certain irony in this, because the idea of promoting the meta-capability to be healthy might initially serve valuable political purposes, especially in a global context, as it can establish the urgency of health problems and their underlying social problems. It might, for instance, be easier to "sell" certain measures such as promoting general literacy in a country when it is seen as a health issue. After all, there is wide agreement that the state is usually seen as being responsible, and having an interest in, the health of citizens, but not their well-being. Yet, this political benefit of a broad notion of health might easily backfire when alleged issues of justice become more and more ubiquitous.

2. THE THRESHOLD PROBLEM

The fact that public health allows for grades of health opens the possibility to discuss health promotion in a way that includes enhancing health over and above the absence of disease. This is the area where worries about "healthism" begin. Health, or being more healthy, understood in a positive sense, like in the definition of the WHO, does not have an internal normative stoppage or threshold of adequate health. More health is always better than less. For egalitarians, more health is also required for some groups as a matter of justice. What is more, the improvement of health is not merely, and maybe not even primarily, a matter of improving the internal resources of a person, such as stamina and nutrition, but also of the social determinants of health, such as quality of the work environment, access to leisurely activities and so on. We can think of many ways to – if only indirectly – improve health dispositions of citizens by improving their environment as well as by changing their lifestyles.

In this section I will scrutinise Venkatapuram's theory further in relation to its commitment to a kind of sufficientarianism. Officially, he has a stoppage point in the pursuit of social justice, which is when a person has the capability to be healthy "at a level that is commensurate with equal human dignity in the modern world".[14] Hence, Venkatapuram sets a threshold to the meta-capability to be healthy. But is it plausible and feasible?

I believe to aim at a core set of vital goals, or an objective core of minimal capabilities, is an important task in political philosophy, not least because it might serve as a basis for an account of human rights and hence as a basis for issues of global justice. Now, it

[14] Venkatapuram 2011, op. cit. note 6, p.12.

seems that the main problem of determining such a set of vital goals is methodological: How can substantive human vital goals be determined and justified? Unfortunately, Venkatapuram is more or less silent in this respect, as he endorses Nussbaum's list of basic capabilities and with it her methodology.

It seems that he in fact deals with two thresholds, one might be called qualitative, the other quantitative. First, he determines, in accordance with Nussbaum, the capabilities that are minimally necessary for dignity. Here, he is concerned with the "package" of capabilities that are minimally required to live a decent life. Venkatapuram can back the list by pointing out the relevance of the items, such as access to recreational activity ("ability to play") or to have "social affiliations that are meaningful and respectful", for health, which is again a value that is rarely put into doubt. The rationale here seems to be that in order to live a minimally decent life one needs to be minimally healthy, and that the social bases of being minimally healthy are indeed the items on Nussbaum's list. Hence the valuableness of the individual capabilities is established by Venkatapuram via relying on the value of health, which is normally not put into doubt in philosophical or public debate. Although such an argument should be challenged, I have accepted its rationale in other sections of this essay. In brief, the main problem here is that the value of health is usually justified by its negative aspect, namely the absence of disease. It is not so clear that health, understood in its welfare dimensions, is or should be important to us as well. This problem is concealed in Venkatapuram's theory because he turns it into a conceptual point that the social conditions we need to live a decent life simply are identical with a capability to be healthy, so that the value of being healthy (understood in this way) cannot seriously be questioned.

The second threshold sets a particular quantity of individual capabilities. Capabilities are gradual notions, such as the capability to be healthy in general. For instance, we might be more or less able to "having emotions and emotional attachments". Now, the target for Venkatapuram is clear. We need so much of the individual capabilities that we reach a level that is commensurate with equal human dignity in the modern world. The exact level of development of these capabilities is apparently to be set by societies in accordance with their own needs and values.[15] Hence this threshold seems to be culturally relative. This is awkward, because Venkatapuram castigated Nordenfelt's

[15] Ibid.: 119f.

approach to health for its relativism.[16] But even ignoring this it seems problematic for his approach that – in making the quantitative threshold relative – there does not seem to be a way to set limits. The more we have of a certain capability, the better. But Venkatapuram's theory is a theory of health justice. It does not seem right to say that we owe to each other the best possible level of basic capabilities, or indeed of the meta-capability to be healthy.

It might be responded that the very fact that we are discussing capabilities, i.e. the ability to reach a level of functioning, allows for people to simply renounce the highest possible level of basic capabilities, but that this level is nevertheless in their interest. However, this reply misses the target, as it would only be in our interest to have access to the highest possible level of capabilities if it would not involve any costs. But this is not the case. Obviously, to socially organise the provision of capabilities is costly, not only in monetary terms. Again, this very problem – the fact that providing certain levels of capabilities might be against our overall interest – tends to be concealed by the all-encompassing notion of a capability to be healthy. Since this notion supposedly covers all that is valuable to people, it seems nonsensical to balance it against any other value.

There might be another way to discuss thresholds of the quantitative kind (and, indeed, of the qualitative kind as well), which is related to issues of health. We might be able to learn about basic or minimal human needs by studying severe cases of disease. Diseases that are seriously debilitating or disabling are bad for us, whereas not to have the highest level of capabilities is not. Such a negative approach – to focus on the bad for people instead of the good – has a more natural partner in the minimal, negative notion of health. Unfortunately, at this point in his argument, Venkatapuram has already abandoned this medical notion of negative health. Yet, I believe it might pose an interesting alternative to his approach that is actually in line with the general gist of his argument.

Many diseases go along with pain or disablement. That is why they are frequently disvalued by most people. Surely there are also diseases that are not harmful in this way, for instance because they are minor or because they affect capacities of people they do not deem relevant to their lives. Yet there are many examples of diseases that impair our well-being. It is these examples where a factual component - whether a certain organismic condition is pathological - and an evaluative aspect mix. Diseases can give us

[16] Ibid.: 43.

evaluative evidence, as it were, of what is good, or rather what is bad, for us. This is why a biomedical theory of disease has certain significance for developing a sufficientarian approach in health care and public health. What is enough in terms of health is based on facts about human disease. We still need an assessment of disease from a human point of view, but this evaluation cannot completely ignore the medical facts. So a proper theory of disease has bearing on theories of health justice.

In summary, in this section I pointed out problems for Venkatapuram to keep his theory within the limits set by sufficientarianism. A certain risk of supporting healthism is endemic to his approach. I believe this risk is related to the underlying theory of health and its broad definition in terms of human welfare.

3. CONCLUSION

I have discussed Venkatapuram's theory in relation to two problems: the metric problem and the threshold problem. I have pointed out issues that should be addressed in future research. Some of these are methodological, for instance regarding the determination of elements on the list of capabilities; some are conceptual, especially regarding the central notions of health and disease. Finally, some issues to be discussed in future research are more practical, most importantly the danger of healthism.

One lesson that might be learned from the debate pursued in this article is that we should not attempt to solve value conflicts by terminological moves. "Everything is what it is", Isaiah Berlin said in his Inaugural Lecture at Oxford University, "Two Concepts of Liberty". Now the ability to live a minimally decent life is the ability to live a minimally decent life, and not the capability to be healthy.

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